

**Sanford Clinic Vermillion-
USD- Student Health**

Medical Exemption to Mandatory MMR Immunization

Name: _____
Last First Middle

Date of Birth: _____ USD Student ID #: _____

Permanent Address: _____
Street City/State/Zip/ Country

In the event of an outbreak I, _____ will be excluded from campus for the duration of the outbreak.

Signature of Student Date

I certify that the above named student should be exempted from the requirements for the measles, mumps, rubella (MMR) Vaccine based on:

___ The following medical reason: _____

_____ which constitutes a medical contraindication in accordance with the advisory committee on immunization practices of the U.S. Public Health Services for MMR vaccine.

___ Adverse reaction to the fist MMR on _____ precludes administration of the second MMR dose.
(Date)

___ Is pregnant or nursing and needs temporary exemption until _____ (fill-in date).

___ Other _____

I certify the physical condition of this student to be such that the inoculation(s) specified on this form would seriously endanger the life or health of this student

Signature: _____ Date: _____

Name (print): _____

Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

A Medical Doctor (M.D.) Or Doctor of Osteopathy (D.O.) must complete this form.