

STUDENT HEALTH SERVICES

Accredited by the Accreditation Association for Ambulatory Health Care, Inc.  
1250 Bellflower Boulevard Long Beach, California 90840 Fax: (562) 985-1644

MEDICAL EXEMPTION REQUEST FORM

Full Name of Student: \_\_\_\_\_ Phone #: \_\_\_\_\_

Student's Campus ID: \_\_\_\_\_

Student's Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_ (Name of licensed, board-certified MD, DO, PA, NP) have reviewed the CSU immunization requirements and hereby certify that the above-named student has a medical condition that contraindicates their vaccination with the following vaccine(s):

\_\_\_\_\_ MMR                      \_\_\_\_\_ Meningitis                      \_\_\_\_\_ Tdap (pertussis)  
\_\_\_\_\_ Hepatitis B                      \_\_\_\_\_ Varicella (chicken pox)                      Other: \_\_\_\_\_

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