AURORA UNIVERSITY

Wellness Center

630-844-5434 • 630-844-5611 (fax)

Immunization Exemption: Medical Reason

To be completed by student:

Student:	**SSN:**	**Date:**
I am requesting medical exemption from the immunization requirements. **Student Signature:**____		

To be completed by physician:

Please evaluate the above named student's medical status and indicate below reason for medical exemption from the required immunizations.

	Tetanus/Diphtheria	**MMR**
Please indicate which immunization student needs medical exemption from.		

Reason for medical exemption:

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If pregnant please indicate estimated due date:

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Physician Signature:__________________________	**Physicians Name:**______________________ **Address:**____________________________ **Phone Number:**________________________