Department of
Student Health and Wellness

MEDICAL EXEMPTION

***Does not apply to Tuberculosis (TB) Screening/Testing or COVID**

Student Name: ____

University ID: ____ Date of Birth: ____/____/______

As specified in the Code of Virginia §23.1-800, I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

- ☐ DTP/DTap/Tdap
- ☐ DT/Td
- ☐ OPV/IPV
- ☐ Measles
- ☐ Rubella
- ☐ Mumps
- ☐ Hepatitis B
- ☐ Hepatitis
- ☐ Varicella
- ☐ Meningococcal

This contraindication is: ☐ Permanent ☐ Temporary

And expected to preclude immunizations until: Date: ____/____/______

HEALTH CARE PROVIDER:

Signature of Medical Provider/Health Department Official: ____

Medical Provider Printed Name: ____**Date:** _______________

Address: ____**Phone:** ____-____-_____

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