



CAL POLY

Campus Health & Wellbeing

Cal Poly State University
Campus Health & Wellbeing
One Grand Ave, San Luis Obispo, CA 93407-0210
Phone: 805-756-1211; Fax 805-756-5298

Full Name of Student: _____

Student's Date of Birth: _____

I, _____ [Name of licensed MD, DO, PA, NP] have reviewed the California Polytechnic State University Immunization Exemption Policy, and hereby certify that the above-named student has:

A medical condition that contraindicates his/her vaccination with _____ vaccine:

Please check the appropriate box and list below either: (list only 1 vaccine per section)

- a) The applicable CDC contraindication to this vaccine*, or
- b) The applicable manufacturer's vaccine insert contraindication to this vaccine*, or
- c) The physical condition of the person or medical circumstances relating to the person that are such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances* that contraindicate immunization with this vaccine*

***REQUIRED: Description of contraindication meeting criteria a, b, or c above:**

This contraindication is: Permanent or Temporary

If temporary: The expiration date of the exemption for this vaccine is: _____

Titers for immunity to this disease: (Please attach photocopies of any titer results if done)

Indicate that he/she is immune Indicate he/she is NOT immune Have not yet been obtained

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Please check the appropriate box and list below either: (list only 1 vaccine per section)

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A medical condition that contraindicates his/her vaccination with _____ vaccine:

Please check the appropriate box and list below either: (list only 1 vaccine per section)

- d) The applicable CDC contraindication to this vaccine*, or
- e) The applicable manufacturer's vaccine insert contraindication to this vaccine*, or
- f) The physical condition of the person or medical circumstances relating to the person that are such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances* that contraindicate immunization with this vaccine*

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This contraindication is: Permanent or Temporary

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Titers for immunity to this disease: (Please attach photocopies of any titer results if done)

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Signature of Medical Provider:

Date:

Medical License Number & State/Country of Issue:

Practice Address:

Provider Phone Number & Email:

For Use by Campus Health & Wellbeing Staff Only: _____

- Date Approved: _____
- Date Denied: _____
- Date Entered PyraMED: _____

Students: Return this completed form to Cal Poly Campus Health & Wellbeing by mail or fax.