

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 Californi State University Immunization Exemption Policy, and hereby certify that the above-named student has:	a Polytechnic
A medical condition that contraindicates his/her vaccination with	vaccine:
Please check the appropriate box and list below either: 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 not considered safe, indicating the specific nature of the medical condition or circumstances* that contrain 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	
A medical condition that contraindicates his/her vaccination with	vaccine:
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Indicate that he/she is immune Indicate he/she is NOT immune Have not yet been obtained	

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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)	
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 im-	munization is
not considered safe, indicating the specific nature of the medical condition or circumstances* that contraindic	
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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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A medical condition that contraindicates his/he	er vaccination with		vaccine:
Please check the appropriate box and list below		(list only 1 vaccine per section)	
a) The applicable CDC contraindication	n to this vaccine*, or		
b) The applicable manufacturer's vacci	ne insert contraindicatio	n to this vaccine*, or	
	fic nature of the medical	es relating to the person that are such that in condition or circumstances* that contraind	
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f) The physical condition of the person	or medical circumstance	es relating to the person that are such that in	nmunization is
		condition or circumstances* that contraind	
immunization with this vaccine*			
*REQUIRED: Description of contraindi	ication meeting criteria	a. b. or c above:	
THE QUILLEST E CONTINUE OF COMMUNICATION		<u> </u>	
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This contraindication is: Permanent or	Temporary		
If temporary: The expiration date of the e	1		_
Titers for immunity to this disease: (Please atta	ch photocopies of any ti	iter results if done)	
Indicate that he/she is immune Ind	dicate he/she is NOT imi	mune Have not yet been obtained	
Signature of Medical Provider:	Date:	Medical License Number & State/Co	ountry of Issue:
Practice Address:		Provider Phone Number & Email:	
Therice Hadress:		Trovider Thone Tramoer & Emair.	
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	`Only:		
For Use by Campus Health & Wellbeing Staff Date Approved:	•		
For Use by Campus Health & Wellbeing Staff Date Approved: Date Denied:	•		

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

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