

**UNIVERSITY OF VERMONT
IMMUNIZATION EXEMPTION FORM**

Vermont's School Immunization Regulations apply to any students in attendance at any public or independent kindergarten, any elementary or secondary school, and certain post-secondary schools. Before school entry, students must have the required immunizations unless exempt for medical, religious, or moral (philosophic) reasons. In order to claim an exemption, this form needs to be completed, signed, and returned to the school.

Please note that students who claim an exemption may be kept out of school during the course of a disease outbreak. The reason for this is that such students will be at high risk for getting that disease and, in turn, transmitting it to other students. The length of time a student is kept out of school will vary depending on the type of disease and the circumstances surrounding the outbreak. This may be from as little as several days to over a month.

This document is being submitted on behalf of the following student:	
Name:	Date of Birth:
_____	____/____/____
Last	First

MEDICAL EXEMPTION	
The following vaccine(s) is/are medically contraindicated:	
<input type="checkbox"/> DTaP/DTP	<input type="checkbox"/> Td/Tdap
<input type="checkbox"/> Polio	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Varicella	<input type="checkbox"/> Measles
<input type="checkbox"/> Mumps	<input type="checkbox"/> Meningococcal
Reason for exemption(s): _____	
This exemption shall continue until: ____/____/____	
_____	(____)
Print Name of Physician	Telephone number
_____	____/____/____
Signature of Physician	Date

MORAL (PHILOSOPHIC) EXEMPTION		RELIGIOUS EXEMPTION	
I request that the following immunization(s) be waived because they conflict with the free exercise of religious and/or moral (philosophic rights):			
<input type="checkbox"/> DTaP/DTP	<input type="checkbox"/> Td/Tdap	<input type="checkbox"/> Polio	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Varicella	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Meningococcal
_____		(____)	____/____/____
Signature of Student	Telephone number	Date	