Exemption Declaration

Please fill out the form in ink. Information must be legible to be accepted

College of Health Sciences Program:
700 University Ave.
Monroe, LA 71209
A Member of the University of Louisiana System*AA/EOE

Name:_____ **Date of Birth:**_____

CWID:_____ **Semester/Year Enrollment:** _____

ULM Email:_____ **Phone: (_____)**_____

My exemption declaration applies to the following vaccinations (circle all that apply):

MMR 1st dose MMR 2nd dose Tdap Meningitis Hep B Series

COVID-19 Flu Other: _____

Reason for exemption for the above-referenced immunization(s):
□ Medical (Physician's statement required)
□ Personal/ Philosophical

Understand the Risks and Responsibilities

Pursuant to Louisiana R.S. § 17:170: In the event of an outbreak of a vaccine-preventable disease at University of Louisiana Monroe, the administrators are empowered, upon the recommendation of the Office of Public Health, to exclude from attendance unimmunized students until the appropriate disease incubation period has expired or the unimmunized person presents evidence of immunization.

By signing below, I understand that by claiming an exemption, I may be excluded from campus and from classes in the event of an outbreak until the outbreak is over or until I submit proof of immunizations. For students in academic programs in which external-based experiences are mandated in the respective program curriculums (i.e., clinical hours, experiential field placement, teacher education credits, etc): By choosing not to immunize, I understand that I may be delayed in obtaining clinical or field hours, progressing in clinical or field courses, or graduating in the event of an outbreak of a related disease until the outbreak is over or until I submit proof of immunization(s). I understand that by declining any required vaccinations, I continue to be at risk for serious disease and will be subjected to regular testing. I can always receive the vaccine(s) at any time. I have read and understand the vaccine information from the CDC at https://www.cdc.gov/coronavirus/2019-nCoV/index.html and understand risks and responsibilities in exempting/declining the required immunizations.

Student Signature: _____ **Date:** _____

If student is not 18 years of age, legal guardian must sign below.

Parent or Guardian Signature (if required): _____ **Date:** _____

COHS Programs to retain an electronic or hard copy of this form for their records.

Medical Exemption Physician Statement

I am a physician licensed to practice medicine in a jurisdiction of the United States. By signing below, I certify that for _____ (patient name), the following vaccine(s) is(are) contraindicated for medical reasons (circle all that apply):

MMR 1st dose **MMR 2nd dose** **Tdap** **Meningitis** **Hep B Series**

COVID-19 **Flu** **Other: _____**

The contraindication(s) is(are): □ Permanent □ Temporary

If temporary, the contraindication is expected to preclude immunizations until: Date _____

Physician Information

Physician Signature:_____Date:_____

Physician Name: _____

Physician Specialty: _____

Physician License Number: _____

Name of Physician Company: _____

Address: _____

Email: _____Phone: _____

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