Stanford | Vaden Health Center

Application for Medical Exemption from Vaccination

866 Campus Drive
Stanford, CA 94305-8580
Phone: (650) 498-2336

Name of Student: _____ DoB: _____ Stanford ID: _____

Student Signature: _____Date: _____

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Name of Healthcare Provider: _____ Phone #: _____

License #: _____ Expiration Date: _____ State of Issue: _____

Practice Address/Email Address:_____

I hereby certify that the above-referenced patient qualifies for a medical exemption from the following ***required*** vaccine(s):

[ ] Measles* **[ ]** Hepatitis B** **[ ]** Covid-19** (be specific): _____
[ ] Mumps* **[ ]** Varicella** **[ ]** Influenza**
[ ] Rubella* **[ ]** Tetanus/Diptheria/Pertussis (Tdap)**

**vaccine required for ALL students* ***vaccine required for medical/physician assistant students only*

Reason: **[ ]** CDC Contraindication **[ ]** CDC Precaution **[ ]** Manufacturer's Insert Contraindication **[ ]** Other
[ ] Severe allergic/other reaction following a dose the vaccine
[ ] Known (diagnosed) allergy to a component of the vaccine **[ ]** Other medical circumstance preventing vaccination

Provide a ***summary*** explanation for vaccine exemption here regardless of reason indicated above. **Supporting clinical documentation must be attached for this request to be considered:**

_____
_____
_____

This contraindication or precaution is: [ ] Permanent [ ] Temporary for _____
Duration

I hereby certify that I provide regular health care for the patient above, and I am not submitting this request as a relative or personal family friend.

Provider Signature: _____Date: _____

Completed forms may be mailed to Vaden Health Center (address above) or submitted through ServiceNow at https://stanford.service-now.com/student_services (Student Health; Inquire about Student Health Requirements)

For official use only: **Date: _____**

Approved Exemption(s): _____

Denied Exemption(s): _____

Approver Name/Signature: _____

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