Jefferson
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Request for Medical Exemption - Immunization

Date of Request: _____

Name: _____ Phone_____

DOB: _____/_____/_____

SITE: East Falls or NJ campus ONLY

DEPARTMENT/SCHOOL: _____ Job Title: _____

Supervisor/Director: _____ Ext: _____ - _____

Dear Healthcare Provider:

The above student is requesting a medical exemption from immunization due to an adverse medical response from the vaccine. Please complete one form for each vaccine request.

Vaccine_____

My patient should not be vaccinated for the following reason(s):

_____

_____

_____

I certify my patient has the above contraindication(s) and request a medical exemption for vaccination.

Healthcare Provider Signature: _____ NPI #_____
(Signature only – stamp NOT accepted)

Healthcare Provider Name/Credentials: (PRINT): _____Phone: _____

Date: _____

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Jefferson Approval: _____ Date: _____

☐ Approved ☐ Not Approved