EMBRY-RIDDLE
Aeronautical University
PRESCOTT, ARIZONA

REQUEST FOR EXEMPTION TO IMMUNIZATIONS
ERAU WELLNESS CENTER

If you wish to become exempt from immunization requirements, this form must be completed, signed and returned to ERAU Wellness Center. By state law,(A.R.S.-15-873) you will not be allowed to attend classes at ERAU until either a record of immunization or this exemption statement is submitted. Please indicate below the type of exemption requested and complete ALL required information. **In the event of an outbreak of a vaccine preventable disease for which you cannot provide proof of immunity, you will not be allowed to attend classes at ERAU until the risk period ends.**

MEDICAL REASONS – If the immunization would be a health risk to the person because of pre-existing medical conditions, you must sign the statement below, ***along with your physician's or nurse practitioner's signature***. You physician must state the reason for the medical exemption. The exemption may be for one or more vaccines and may be either permanent or temporary. If the condition is temporary, the date of its end must be given, at which time you must receive any necessary vaccine does.

PERSONAL BELIEFS - If immunizations are against your personal beliefts, you must sign below to be exempt from the requirements.

LABORATORY EVIDENCE – If you have previously had a vaccine preventable disease, immunization against that disease is not required if laboratory evidence of immunity, signed by a physician, can be provided. *Copies of lab results must accompany this request.*

Patient's Name: _____ Date of Birth:_____
(please print)

Type of exemption requested:
(Mark one)

_____Medical * (See below)
_____Personal Beliefs
_____Laboratory Evidence

For the following vaccines:
(Mark all that apply)

____Mumps ____Mumps ____Rubella
____Meningococcal ____Hepatitis B

*If a medical exemption is marked, please complete the following:

Reason for medical exemption:
_____

Length of exemption:
_____Permanent _____Temporary (until _____)

Required Signatures: Parent, Guardian or Patient must sign request and physician must also sign for any requests for medical, laboratory evidence or religious beliefs exemptions:

_____ Date_____
Parent, Guardian or Patient

_____
Print Name

_____ Date_____
Physician

_____
Print Name