UNIVERSITY OF
INDIANAPOLIS

Request for a Waiver from the Immunization Requirement

Student Information

Name: _____

Student #: _____

Current Mailing Address: _____

ADDRESS CITY STATE ZIP CODE

Email Address: _____

Date of Birth: _____ Current Phone: _____

Reason for Your Request:

☐ Medical ☐ Religious ☐ Philosophical/Personal

I understand that in the event of an outbreak of a vaccine-preventable disease on campus, I may be excluded from university classes, housing, or campus activities for public health reasons.

By signing this form, I understand that choosing not to be immunized may increase the risk of contracting and spreading vaccine-preventable diseases. I accept full responsibility for my health and understand the implications of non-compliance with university and public health guidelines.

Student Signature: _____ **Date:** _____

Health Care Provider Documentation (required for medical request):

I certify that this student has legitimate medical reasons for inadequate immunity because (state reason):

_____

_____

_____ _____

HEALTH CARE PROVIDER'S SIGNATURE/DATE PRINT NAME AND TITLE

Provider Address: _____ Provider Telephone: _____

_____

Upload this completed form to your Med+Proctor student account.