Wellness Center
(phone) 630-844-5434
(fax) 630-844-5611

Immunization Exemption: Medical Reason

To be completed by student:

Student:	**SSN:**	**Date:**
I am requesting medical exemption from the immunization requirements. **Student Signature:**_____		

To be completed by physician:

Please evaluate the above named student's medical status and indicate below reason for medical exemption from the required immunizations.

	Tetanus/Diphtheria	**MMR**
Please indicate which immunization student needs medical exemption from.		

Reason for medical exemption:

_____

_____

_____

If pregnant please indicate estimated due date:

_____

Physician Signature:_____	**Physicians Name:**_____ **Address:**_____ **Phone Number:**_____