WINTHROP UNIVERSITY
Center for Student Wellness

Center for Student Wellness
Division of Student Affairs
217 Carwford Building
Rock Hill, SC 29732
Phone: 803/323-2206 Fax: 803/323-3332

Immunization Waiver Medical Contraindication

Date: _____/_____/_____

RE: _____
Name Print

_____ _____
WU ID# Date of Birth

_____
Address Street City State Zip

_____
Phone Number

Provider:
I certify that the individual named herein is exempted from receiving each of the vaccines listed below for a **MEDICAL REASON**.

Vaccine(s)	Date Exemption Expires	*Or* Permanent Exemption	Medical Reason(s)
	/ /	[ ]	
	/ /	[ ]	
	/ /	[ ]	
	/ /	[ ]	

_____ _____
Healthcare Provider's Name (please print or stamp) Signature

_____
Address Street City State Zip

_____
Phone Number

Student:
I, (print student name) _____, understand that in the event of an outbreak of a vaccine-preventable disease for which I have not been immunized, I may be excluded from Winthrop University. I understand that the University will not be responsible for any classes missed and any fees paid are not refundable.

Student Signature: _____ Date: ____/____/____
Name