WINTHROP UNIVERSITY | Center for Student Wellness

Immunization Waiver - Medical Contraindication

Student Name: Date of Birth: WU ID:

I certify that the individual listed on this form, and in my medical care, 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 Printed Name (please print or stamp) Signature Date

_____

Address City State Zip

_____

Phone Number

Student:

I, (print student name) _____, understand that if a vaccine-preventable disease outbreak occurs and a student has not been immunized or provided proof of immunity, the **South Carolina Department of Public Health may require their exclusion from the University for a specified period of time.** In such cases, **Winthrop University is not responsible for missed classes, and tuition and fees will not be refunded.** During this time, students should follow the Absence Notification process on the Dean of Students website to notify instructors and coordinate regarding missed coursework.

Student Signature: _____ Date: ____/____/____