



**Aurora
University**

Wellness Center
347 S. Gladstone Ave.
Aurora, IL 60506-4892
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: _____ |