



**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 Online Program
- Coronavirus, Cannot See Doctor

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/Title/Date

Print Name and Title

Address: _____

Telephone: _____

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