Hamilton

The Joel and Elizabeth Johnson Center for Health and Wellness

REQUEST FOR MEDICAL EXEMPTION TO IMMUNIZATIONS FORM

Please Print:

Student Name: _____ Date of Birth: _____

Student ID#; _____ Grad Year: _____

This form is to be completed by your health care provider for a medical exemption to Public Law immunization Requirements. Please have your Primary Health Provider complete the following information below.

Diagnosis: _____

_____

_____

_____

_____

_____

Date of Diagnosis: _____

Date Medical Exemption in effect until: _____

Health Care Provider (please print):

Name: _____ Signature: _____

Address: _____

Phone #: _____ Fax#: _____

For Hamilton College Health Center Use Only:

Date Received: _____

Reviewed By: _____

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www.hamilton.edu/college/health_center