MEDICAL EXEMPTION REQUEST FORM

Please return to CSUB Student Health Services upon completion.

Student's Full Name: ___________________________________ Date of Birth: ____________________

CSUB ID Number: ______________________________ Phone Number: _________________________

I, _________________________________ (name of licensed, board-certified MD, DO, PA, NP), have reviewed the CSU immunization requirements and hereby certify that the above-named student has a medical condition that contraindicates their vaccination with the following vaccine:

☐ Hepatitis B

The physical condition of the student, or medical circumstances relating to the student, are such that immunization is not considered safe. The specific nature of the medical condition or circumstances that contraindicate immunization with this vaccine(s) are indicated below.

Description of Contraindication:

____

____

____

This contraindication is ☐ Permanent or ☐ Temporary

If temporary: The expiration date of the exemption for this vaccine is: _________________________

____

Signature of Medical Provider | Date | Medical License Number and State/Country of Issue

____

Practice Address | City | State | Zip

____

Provider Phone Number | Provider Email

DISCLAIMER: Medical exemptions are evaluated on a case-by-case basis. Medical records may be requested by CSUB Student Health Services for review prior to granting a medical exemption.

In active infections disease outbreak situations, I, ___________________________________ (print student's name), may not be allowed to come to campus or I may have to leave the residence halls. I understand these situations will be determined on a case-by-case basis, in consultation with state and local public health officials.

Student Signature: ______________________________________ Date: _______________

Student Health Services
California State University, Bakersfield
9001 Stockdale Hwy. • 28-HC • Bakersfield, CA 93311

661.654.2394 661.654.3301 Fax *csub.edu/healthcenter*