Utah State University Immunization Waiver Request Form

Student’s Name: ____________________________________________________________

Student’s A#: ___________       Date of Birth: ________________

Utah State University recognizes that immunization against infectious illness is safe, effective and one of the best ways of preventing serious infectious disease outbreaks. Vaccine-preventable diseases can cause serious illness and even death. The University also recognizes that individuals and their parents have the right to make the decision whether or not individual students receive vaccinations. If you have any questions about the benefits and risks of immunization, please contact your healthcare provider or local health department or the University Student Health Services.

The illnesses for which vaccination is required or recommended that are covered under this waiver include: (Check those that apply)

☐ Tetanus, Pertussis and Diphtheria. (covered wholly, or in part by DTaP, DT, Tdap, or Td vaccinations)
☐ Polio (covered by Polio vaccinations)
☐ Measles, Mumps and rubella (covered by the MMR or individual vaccinations)
☐ Hepatitis A and B (covered by Hepatitis A and B vaccination series)
☐ Varicella (covered by Varicella vaccine or having had chickenpox)
☐ Meningitis (covered by Meningococcal vaccine)

I am requesting an exemption for:

I, or a minor child’s parent/guardian, am opposed to having the above-named individual receive the immunizations checked above for the following reason(s)

________________________________________________________________________
________________________________________________________________________
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As the individual covered by this waiver, or the parent/guardian, if the individual is a minor, I understand that in the event of a disease outbreak the individual may be excluded from classes and activities for the duration of the outbreak, both for his/her own protection and for the protection of others. I acknowledge that I have read this document in its entirety.

Signature of Individual, Parent or Guardian ________________________________

Name of Signer (PRINT)_____________________________       Date:______________

When completed, please:
FAX a copy to 435 797-3585, email a copy to ship@usu.edu or upload as a scanned document at aggiehealth.usu.edu