Immunization Exemption Request Form

Please complete the appropriate section below regarding your exemption request. This document needs to be signed by a licensed Health Care Provider (MD, DO, NP or PA). Exemptions will not be approved until this form is completed and is received by NDSU Student Health Service. For more information, visit www.ndsu.edu/studenthealthservice or call 701-231-7331.

REQUIRED INFORMATION

Name __________________________

Last Name __________________________ First Name __________________________ Middle Initial ________ Former Name __________________________

Birthdate __________________________ NDSU ID # __________________________ Phone # __________________________

Month/Day/Year

UPLOAD DOCUMENTS ONLINE HERE: OR FAX TO:

www.ndsu.edu/studenthealthservice 701-231-6132

• DOCUMENTATION MUST BE SUBMITTED IN ENGLISH

☐ MEDICAL EXEMPTION

Students requesting an exemption due to a medical condition(s) must have a Provider complete this section.

I certify that it would be harmful to this student’s health to be immunized against the following disease(s):

__________________________________________________________________________

Check one: ☐ Permanent exemption ______________________  ☐ Temporary exemption: Date to be released: ______________

☐ BELIEF EXEMPTION

Students requesting a belief exemption must schedule an appointment with a Provider to go over the risks of not being immunized. Please give detailed information below.

I hereby certify that immunization(s) __________________________________________
is contrary to my beliefs because __________________________________________

__________________________________________________________________________

I understand that requesting this exemption does carry risk. In the event of an outbreak of a communicable disease in which immunization is required (see website for required immunizations), Student Health Service staff and/or the local public health officer will determine exclusions from campus and campus activities until the danger of the epidemic is over.

Student signature: __________________________________________________________ Date: ______________

REQUIRED HEALTH CARE INFORMATION (This form will NOT be accepted if this section is not completed.)

Provider’s signature: __________________________________________________________

Date: ______________ Facility name/location: __________________________

NDSU does not discriminate in its programs and activities on the basis of age, color, gender expression/identity, genetic information, marital status, national origin, participation in lawful off-campus activity, physical or mental disability, pregnancy, public assistance status, race, religion, sex, sexual orientation, spousal relationship to current employee, or veteran status, as applicable. Direct inquiries to: Vice Provost, Title IX/ADA Coordinator, Old Main 201, 701-231-1708, ndsu.eara@ndsu.edu.