

REFUSAL OF VACCINATION

Louisiana State University Health Sciences Center - Student Health Services

Name: _____ Semester of Enrollment: Fall ____ Spring ____ Summer ____

Please Print (Last) (First) (M.I.)

Address: _____ 20____ Email: _____
(Street/ P.O. Box) (City) (State) (Zip Code)

Date of Birth: _____ EMPLID Number: _ _ _____ Telephone: (____) _____

I, the above-named student, request an exemption for the following vaccine(s). (Check all that apply.)

- | | |
|---|--------------------------------|
| <input type="checkbox"/> HEPATITS B | <input type="checkbox"/> COVID |
| <input type="checkbox"/> MENINGOCOCCAL CONJUGATE (ACWY) | |
| <input type="checkbox"/> MEASLES/ MUMPS/ RUBELLA | |
| <input type="checkbox"/> TETANUS | |
| <input type="checkbox"/> VARICELLA | |

I request an immunization exemption, based on the following reason(s):

- Medical**
- Personal/ Religious**
- Shortage (unable to locate vaccine)**

I understand that by submitting this form for any of the required vaccines, I exempt at my own risk.

I have received and reviewed information from the Centers for Disease Control and Prevention (CDC) website at <https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html> regarding vaccine preventable diseases and related vaccinations and have chosen not to be vaccinated.

I release Louisiana State University Health Sciences Center of New Orleans, its faculty, staff and students from any and all claims, connected with an exposure, outbreak or threatened outbreak of disease or other public health emergency on campus.

I understand that if I claim exemption for any of the reasons stated above, I may be excluded from campus and from classes in the event of an outbreak of a related disease until the outbreak is over or until I submit proof of immunization(s).

If I am under 18 years of age, I understand that my parent or legal guardian must also sign below.

I understand that I may not be able to participate in clinical activities based on the regulations of the hospital or clinic.

Student Signature

Date

Parent or Legal Guardian (if required)

Date

****PLEASE UPLOAD COMPLETED FORM TO: [THE STUDENT HEALTH SUBMISSION PORTAL](#)**

***Go to the LSU Health New Orleans Homepage, click MYLSUHSC>Self Service>Academic Self-Service, you must login and continue to upload your completed form.**