

### Request for Exemption From Immunization Requirement: Medical

Students enrolled in the College of Health Sciences (“CHS”) may request an exemption related to a CHS vaccination requirement by completing this form and returning it to their program director and the CHS contracts team. This information will be used by appropriate University personnel to engage in an interactive process to determine eligibility for and to identify potential accommodations or exemptions. If a student refuses to provide sufficient information, the refusal may impact the University’s ability to adequately understand the individual’s request or effectively engage in the interactive process to determine if an exemption or reasonable accommodation is possible.

Student Name: \_\_\_\_\_ SUID Number: \_\_\_\_\_

School and Program Enrolled: \_\_\_\_\_

Date of Request: \_\_\_\_\_

#### Student Statement:

I understand CHS, in accordance with the recommendations of the American College Health Association and based on the standard requirements of hospitals and other clinical sites that accept CHS students, requires each student to submit documentation of certain immunizations. I request an exemption from this requirement on the grounds that such immunization(s) would pose a medical risk for me.

I have been informed of the benefits and risks of immunization against vaccine-preventable diseases and the risks of not being immunized. I understand that, in the event of a public health emergency including an outbreak of a vaccine preventable disease for which I have not been immunized, I may be subject to exclusion from campus at the University’s discretion. I agree to assume the risks resulting from declining these vaccines, and I agree to indemnify and hold harmless Samford University from any liability resulting from my declining these vaccines.

I understand that Samford’s approval of my exemption request does not have an impact on the vaccination requirements of any clinical site. I therefore acknowledge that my ability to be placed at a clinical site may be negatively impacted by my lack of immunizations required by any given clinical site and, as a consequence, if I am unable to be placed at a clinical site my degree progress may be delayed or hindered.

This request must be accompanied by a completed, signed, and acknowledged “Affidavit of Medical Objection to Vaccination.” In some cases, the University will need to obtain additional information and/or documentation about the student’s medical reasoning or diagnosis associated with the requested exemption.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Name (print)

\_\_\_\_\_  
SU ID Number

\_\_\_\_\_  
Signature of Parent or Guardian (if under 19)

\_\_\_\_\_  
Date

**Provider Statement:**

I, \_\_\_\_\_, (*Name of licensed MD or DO*) hereby certify that the above-named student has:

A medical condition that contraindicates his/her vaccination with \_\_\_\_\_ vaccine.

Please check the appropriate box:

- The applicable CDC contraindication to this vaccine\*, or
- The applicable manufacturer’s vaccine insert contraindication to this vaccine\*, or
- The physical condition of the person or medical circumstances relating to the person that are such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances\* that contraindicate immunization with this vaccine\*

\*REQUIRED: Description of contraindication meeting at least one of the criteria above:

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This contraindication is: \_\_\_\_\_ Permanent  
\_\_\_\_\_ Temporary (Expiration date of the vaccine exemption \_\_\_\_\_)

Provider Name: \_\_\_\_\_

Provider Credentials: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Provider Office Name: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_

Office Address: \_\_\_\_\_

**Student Verification and Accuracy**

I verify that the information I am submitting in support of my request for an exemption or accommodation is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action. I also understand that my request for an exemption or accommodation may not be granted if it is not reasonable, if it poses a direct threat to the health and/or safety of others in the workplace, school environment, housing facilities and/or to me, or if it creates an undue hardship on the University. I verify that I have communicated with school leadership about my request for an exemption or accommodation.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dean Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Chair Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AFFIDAVIT OF STUDENT MEDICAL OBJECTION TO VACCINATION**  
**(College of Health Sciences)**

\_\_\_\_\_ (*print name of student*) personally affirms that the following is true and correct:

1. I, the undersigned, certify that I am at least nineteen (19) years of age and competent to make this affidavit.
2. I understand that Samford University (University) and its College of Health Sciences (CHS) require students to receive certain vaccinations and provide documented proof of such vaccinations before being enrolled at the University, to participate in certain academic majors, disciplines or programs, and/or allowed to routinely appear on campus.
3. I have received, and I have read and am familiar with University Policy titled *Student Immunizations* (the “Immunization Policy”).
4. I sincerely affirm that the \_\_\_\_\_ vaccination(s) is a contraindication confirmed by a physician, and that my objections to this vaccination are not based solely on grounds of personal philosophy, preference or inconvenience.
5. I understand and accept that I may be excluded from on-campus facilities, including student housing facilities, during an epidemic, pandemic or threatened epidemic or pandemic of any disease preventable by a vaccination required by the University.
6. I acknowledge and understand that some clinical placement sites may require CHS students to have certain immunizations or tests that are not compulsory pursuant to the Immunization Policy and irrespective of any medical or religious exemption that I may be granted by the University. I understand that most clinical sites will require immunization irrespective of any exemption provided by the University. Therefore, the University cannot make any representations or offers assurances that any alternative clinical placements can or will be available and this may affect my academic status (e.g. full time versus part time), eligibility for financial aid, academic schedule, graduation date, licensure eligibility and employment prospects.
7. I understand and accept that the University has no control over the vaccination or test requirements of clinical partners, therefore clinical opportunities may be restricted by the clinical sites and may delay or hinder my degree progress and graduation date.
8. I further acknowledge and understand that even if I am granted an exemption or accommodation, my continuing enrollment at the University may later require that I receive the vaccination if required by applicable law (including public health orders), in the event of an emergency or epidemic/pandemic of disease, or new healthcare information leads the University to determine that continuing the exemption or accommodation is no longer advisable.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Printed): \_\_\_\_\_