KENTUCKY STATE UNIVERSITY
SCHOOL OF NURSING
MEDICAL WAIVER (EXEMPTION) FOR VACCINATION

SECTION 1: To be completed by student

Please print

____ Student ID: _______________________
Full name (First, Middle, Last)

SECTION 2: To be completed by the primary health care provider (physician or nurse practitioner)

Vaccine(s) Exemption Requested:

Seasonal Flu Vaccine ____ Hepatitis B ____ Other (specify) ________________________________

Medical Reason(s):

Severe Egg or Yeast Allergies ______ Previous Severe Reaction to Vaccination ______

Previous Guillain-Barre syndrome within six (6) weeks of receiving an influenza vaccine ______

Chronic Medical Condition (details required, see below) _____

Other (details required, see below) _____

Exemption Period:

Permanent Exemption Request _____

Temporary Exemption Request (time frame) ________________

Details:

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____

Provider Name (print): ___________________________________ **Date:** _________________________

Signature (with credentials): ____

Office Stamp/Address & Phone Number

Submit questions to 502.597.5957 or schoolofnursing@kysu.edu