AUGUSTA UNIVERSITY
Student Health

Medical Waiver Form

(Complete one waiver for each vaccine. Must be completed by a Healthcare Provider – cannot be a family member.)

Student's Name _____

Date of Birth _____ Augusta University Student ID # _____

Program of Study _____

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I, (Print name of licensed MD, DO, PA, or NP) _____, affirm the named student above is temporarily medically exempt from the _____vaccine.

The student can begin receiving vaccine/vaccine series beginning (date)_____.

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I, (Print name of licensed MD, DO, PA, or NP) _____, affirm the named student above is permanently medically exempt from the _____vaccine due to an adverse medical reaction or medical contraindication as outlined by the CDC and/or vaccine manufacturer.

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I understand that while my exemption request is pending or if my exemption request is approved, I will be recognized as compliant with the mandatory vaccination requirement. Further, I understand that my protected medical information will be kept confidential. I must follow infection control guidelines and care for patients admitted/seen/diagnosed with communicable illnesses (such as Measles, Mumps, Rubella, Varicella, Hepatitis B, Covid-19, and Influenza) and that I may be exposed to other serious illnesses (including but not limited to tetanus, diphtheria, and pertussis) as my clinical rotations/academic classes require. I will follow transmission-based precautions for patients with symptoms of communicable illness. I understand that if I develop symptoms of communicable illness, I must report to AU Student Health Services for potential rotation/class exclusion until resolution of symptoms. I understand that an exemption from the vaccine or vaccines does not include any required testing for immunity or infection to the disease or illness.

Non-Family Member Healthcare Provider Signature:

_____ Date _____

Healthcare Provider Contact Information (full name/address/phone/fax):

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