San Francisco State University - IMMUNIZATION REQUIREMENTS MEDICAL WAIVER REQUEST FORM

All students must provide proof of immunization before they may register for classes. The SHS recommends that students keep up to date with all recommended vaccinations.

http://www.cdc.gov/vaccines/adults/rec-vac/college.html

Note: Students who were enrolled in a California public school for the seventh grade or higher on or after July 1, 1999 DO NOT currently have to complete and submit this form to provide proof of immunization against Measles, Rubella and Hepatitis B BUT Students are advised to do so as the requirements may change in the very near future.

LAST NAME ______________________ FIRST NAME ______________________ M.I. ______
ADDRESS ______________________
PHONE NUMBER(S) ______________________ DATE OF BIRTH ______
STUDENT ID # _______________ SFSU E-MAIL ______________________ MAJOR ______________________

Please complete this form OR Attach a copy of your Medical Waiver Request Documentation

Mail or Bring this form in person to:
Registrar’s Office, SSB 101
San Francisco State University
1600 Holloway Avenue
San Francisco, CA 94132

Registrar, One Stop
Student Service Center, SSB 101
Phone: 415-338-2350
FAX: 415-338-0588
http://health.sfsu.edu/required.html

SF State Vaccination Requirements

ALL STUDENTS* BORN ON OR AFTER January 1, 1957

Measles, Mumps, Rubella (MMR) Vaccine (2 Doses)
OR Results of a blood test indicating immunity

If you were born before 1957, check with your academic department to see if immunizations are needed for curriculum requirements.

I hereby certify that for medical reasons I recommend that the above named patient should not be vaccinated against Measles, Mumps, Rubella (MMR).

☐ Permanent Recommendation
☐ Temporary Recommendation ending __________ Date

I hereby certify that for medical reasons I recommend that the above named patient should not be vaccinated against Hepatitis B (HepB).

☐ Permanent Recommendation
☐ Temporary Recommendation ending __________ Date

CERTIFICATION BY MD / NP / PA / RN

Name______________________________________________________
Address____________________________________________________
Date_____________________ License #_______

CERTIFICATION BY MD / NP / PA / RN

Name______________________________________________________
Address____________________________________________________
Date_____________________ License #_______

Office Stamp

FOR RELIGIOUS/PERSONAL WAIVERS/EXEMPTION REQUESTS – CONTACT REGISTRARS OFFICE (SEE ABOVE)
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