

## SUNY Potsdam Student Health Services MMR Vaccine Medical Exemption Request Form

### Section I: Student Information

Last Name	First Name	Student Email	Date of Birth	Potsdam ID #

I understand that I am not fully vaccinated against Measles, Mumps, and Rubella (MMR). If there is an outbreak on campus, I may be excluded from class or campus until the risk of exposure has passed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Student (or guardian if under 18)*

### Section II: Medical Exemption Request (to be completed by medical provider)

**Medical Exemption:** For more information see the CDC's [Vaccine Recommendation and Guidelines of the ACIP](#)

**Medical Provider Certification of Contraindication:** I certify that my patient (named above) cannot be vaccinated against Measles, Mumps and Rubella because of the following contraindication:

Severe allergic reaction (anaphylaxis) after a previous MMR or to a vaccine component.  
**Provide the name of the vaccine or the vaccine component and describe the reaction.**

\_\_\_\_\_  
\_\_\_\_\_

Known severe immunodeficiency  
**Please explain, including date of diagnosis and presentation/complications.**

\_\_\_\_\_  
\_\_\_\_\_

Pregnancy. Due date: \_\_\_\_\_

History of thrombocytopenia or thrombocytopenic purpura.  
**Please explain, including date of diagnosis and presentation/complications.**

\_\_\_\_\_  
\_\_\_\_\_

Recent receipt of antibody containing blood product.  
**Please explain, including date of diagnosis and manifestations/complications.**

\_\_\_\_\_  
\_\_\_\_\_

Healthcare Provider Information		Date:	
Name (print):		Address/Clinic Stamp:	
Signature:		Phone:	

Once completed, send the form to this [secure link](#) or mail/fax to Student Health Services (information above).