CALIFORNIA STATE UNIVERSITY, LONG BEACH
STUDENT HEALTH SERVICES
Accredited by the Accreditation Association for Ambulatory Health Care, Inc.
1250 Bellflower Boulevard Long Beach, California 90840 Fax: (562) 985-1644

MEDICAL EXEMPTION REQUEST FORM

Full Name of Student: _____ Phone #: _____

Student's Campus ID: _____

Student's Date of Birth: _____

I, _____(Name of licensed, board certified MD, DO, PA, NP) have reviewed the CSU immunization requirements and hereby certify that the above-named student has a medical condition that contraindicates their vaccination with the following vaccine(s):

☐ MMR ☐ Tdap (pertussis) ☐ Meningitis ☐ Varicella (chicken pox) ☐ COVID-19

The physical condition of the person, or medical circumstances relating to the person, are such that immunization is not considered safe. The specific nature of the medical condition or circumstances that contraindicate immunization with this vaccine(s) are indicated below.

REQUIRED: Description of contraindication:

This contraindication is ☐ Permanent or ☐ Temporary

If temporary: The expiration date of the exemption for this vaccine is: _____

Signature of Medical Provider: Date: Medical License Number & State/Country of Issue:

Practice Address: Provider Phone Number & Email:

Disclaimer: Medical exemptions are evaluated on a case by case basis. Medical records may be requested by SHS for review prior to granting a medical exemption.

In active infectious disease outbreak situations, I, _____ (print student's name), may not be allowed to come to campus OR I may have to leave the residence halls OR be required to quarantine per public health and University guidelines. I understand these situations will be determined on a case-by-case basis, and in consultation with state and local public health officials.

Medical Practice Stamp:

Students: Please email completed forms to BMAC@csulb.edu .