Measles, Mumps, Rubella (MMR) Vaccines Medical Exemption Request Form

To request a medical exemption from the New York state MMR vaccination requirement complete Part I, including the demographics section, the acknowledgement checkboxes, and the signature. Ask your medical provider to complete Part II, and Part III, then submit the completed form to Student Health and Counseling. Completed forms can be emailed to health@geneseo.edu or faxed to 585-245-5744.

Part I. Student Information and Certification:

G#	Last Name	First Name	DOB	Geneseo Email

Check each box to acknowledge:

☐ If my request is granted, I acknowledge that I will be required to understand and comply with SUNY Geneseo's health and safety protocols pertaining to unvaccinated or under-vaccinated individuals. Furthermore, I acknowledge that the consequences of not complying with these regulations may include having a hold placed on my ability to register for future courses or being deregistered from current courses.

☐ I certify that my statements above, and any supporting documentation, are true and accurate.

Signature*: _____ Date:_____

*Student's signature, or parent/legal guardian must sign if the student is under 18 years old as of the first day of classes.
Note: The campus reserves the right to request additional documentation to support a request for a medical exemption.

Part II. Medical Exemption Request (completed by medical provider only)

A licensed medical provider (Physician, Physician's Assistant or Nurse Practitioner) and the requesting student should review the CDC guidance regarding contraindications for MMR vaccine. By completing Part II, Section A of this form the medical provider certifies that all methods of vaccinating against the MMR viruses have been fully considered and that the student has at least one contraindication or precaution that precludes vaccination.

I certify that my patient (named in Part I) cannot be vaccinated with the MMR vaccine because of the following contraindication or precaution:

Contraindication: _____

Precaution: _____

The patient's inability to be vaccinated is:

☐ Permanent

☐ Temporary

If temporary, the expected date of eligibility to become vaccinated is: _____

Part III. Medical Provider Information (completed by medical provider only)

Medical provider signature/stamp or a copy of the medical provider's document must be attached

_____

MD, NP, or PA's Signature:

_____

MD, NP, or PA's Printed Name:

_____

Address, City, State

Stamp