



# Hamilton

## REQUEST FOR MEDICAL EXEMPTION TO IMMUNIZATIONS FORM

*Please Print:*

Student Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Student ID#: \_\_\_\_\_

Grad Year: \_\_\_\_\_

This form is to be completed by your health care provider for a **medical** exemption to Public Health Law immunization requirements. Please have your Primary Health Provider complete the following information below.

**Diagnosis:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date of Diagnosis:** \_\_\_\_\_

**Date Medical Exemption in effect until:** \_\_\_\_\_

**Health Care Provider (please print):**

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

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**For Hamilton College Health Center Use Only:**

**Date Received:** \_\_\_\_\_

**Reviewed By:** \_\_\_\_\_