Hamilton

The Joel and Elizabeth Johnson Center for Health and Wellness

Medical Provider Documentation for Medical Exemption for Immunizations

Student Name _____
Class Year _____
Date of Birth _____

The above named student meets criteria for a medical exemption to the immunizations required by New York State Law or Hamilton College as marked below.

All requests for medical exemptions are subject to the review and approval by the Medical Director of Hamilton College Student Health Services.

- ☐ All required immunizations.
- ☐ Diphtheria/Tetanus: One dose of Tetanus/Diphtheria (Td) or Tetanus/Diphtheria/Pertussis (Tdap) given within 10 years prior to enrollment.
- ☐ Measles, Mumps and Rubella: Two doses of MMR (measles, mumps, and rubella) vaccine administered after the first birthday.
- ☐ COVID-19: Primary series completed and boosted when eligible.

Medical exemptions to receiving tetanus-diphtheria toxoid are limited to:

- ☐ Having received tetanus toxoid or tetanus-diphtheria toxoid within 5 years of enrollment;
- ☐ A hypersensitivity reaction to a prior dose of tetanus toxoid or tetanus-diphtheria toxoid.

Medical exemptions to received measles, mumps and rubella vaccine (MMR) are limited to:

- ☐ Pregnancy or student planning to become pregnant within 3 months;
- ☐ A history of anaphylactic reaction to following egg ingestion or receipt of neomycin;
- ☐ Students with altered immunocompetence. Please attach detailed documentation.

Medical exemptions to receiving a COVID-19 vaccine are limited to:

Hamilton College / 198 College Hill Road / Clinton, NY 13323 / 315-859-4111 / Fax: 315-859-4963
www.hamilton.edu/college/health_center

- ☐ A severe allergic reaction or a severe hypersensitivity reaction to a prior dose of COVID-19;
- ☐ A non-severe allergic reaction or a non-severe hypersensitivity reaction to a prior dose of COVID-19 within 4 hours of receiving the dose; examples include hives, swelling and wheezing;
- ☐ Individuals with underlying medical conditions such as weakened immune systems, autoimmune conditions, or other underlying medical conditions following recommendations from a licensed physician, nurse practitioner or physician assistant. Please provide a specific explanation. Attach additional documentation if necessary.

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Signature of Provider Date

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Office Name Contact Information