Student Name (Please Print) Student ID#

University of La Verne
Student Health Services

DECLINATION TO RECEIVE RECOMMENDED IMMUNIZATION(S) OR INOCULATION(S)

I hereby acknowledge that I am aware the following immunizations or inoculations are recommended for students enrolled at University of La Verne:

____ MMR
____ Tdap
____ PPD
____ Menomune or Menactra (Meningitis)
____ Varivax (Chicken Pox)
____ Hepatitis B Vaccine Series

I decline the above checked immunizations or inoculations because of (check one or more below):

____ A. Medical reason – Official verification must be provided by a licensed physician.

_____ _____
Physician/Clinician name (please print) License #
Licensed as: _____ State of Licensure:

_____

____ B. Personal or religious beliefs against immunizations or inoculations.

I understand that by signing below, I acknowledge that I am / my student (is) aware of the potential consequences of being unvaccinated, including contracting a potentially serious vaccine-preventable disease and transmitting it to others, academic failure and even withdrawal from the school as a result of the disease. I also understand that in case of a disease outbreak, I / my student may be temporarily excluded from campus for my / my student's protection as a result of my / my student's lack of immunity. I hold no one but myself responsible for my declination and the consequence of me / my student being unvaccinated.

_____ _____
Student's Signature Date

_____ _____
Signature of Parent/Guardian/Conservator Date

_____ _____
Reviewed by Student Health Services Staff Member Date

Please return to: Student Health Services