Medical Vaccine Exemption Form

Wagner College Center for Health and Wellness
Phone: (718) 390-3158
Fax: (718) 420-4170
Email: studenthealthservice@wagner.edu
Submit forms via: wagner.studenthealthportal.com

PLEASE READ ATTACHED VACCINE INFORMATION SHEETS COMPLETELY BEFORE SIGNING BELOW!

I, _____, hereby state that I cannot receive vaccinations for the following disease(s) as I have a medical condition for which said vaccine(s) is/are contraindicated.

I have attached a letter from my medical doctor documenting my medical diagnosis and how this supports declination of the following vaccines.

Please check all that apply:

- ☐ Covid-19
- ☐ Influenza

By signing below, I acknowledge that I understand the information that has been provided to me regarding the disease(s) indicated above. I understand the risk of not receiving the vaccine(s). I have decided that I (my child) will not obtain immunization(s) against the disease(s) indicated above. I accept full responsibility for my (my child's) health and I release Wagner College Center for Health & Wellness and supporting personnel from liability resulting from refusal.

Signature: _____ Date: _____

(Parent/Guardian if student is a minor)

Student name: _____ Date of birth: __/____/__

(Printed)

E-mail Address: _____ ID#: _____

Address: _____

Phone Number: _____