Stanford | Vaden Health Center

Application for Medical Exemption from Vaccination

866 Campus Drive
Stanford, CA 94305-8580
Phone: (650) 498-2336

Name of Student: ____ DOB: __________________________

Student Signature: ____ Date: __________________________

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Name of Healthcare Provider: ____ Phone #: ____________________

License #: _____________________________ Expiration Date: __________________ State of Issue: ________________

Provider Phone/Email Address: ____

Practice Address: ____

I hereby certify that the above-referenced patient qualifies for a medical exemption from the following vaccine(s), as further explained below:

Name of Vaccine(s) (For COVID-19, be specific): ____

Reason: [ ] CDC Contraindications [ ] CDC Precaution [ ] Manufacturer's Insert Contraindications [ ] Other

Provide a detailed explanation for vaccine exemption here regardless of reason indicated above:

____
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____
____

This contraindication or precaution is: [ ] Permanent [ ] Temporary

If temporary, please provide length of time: ____

I hereby certify that I provide regular health care for the patient above, am not a relative or personal /family friend, and the contraindication is well documented in their health record.

Provider Signature: ____ Date: ______________________

Completed forms may be mailed to Vaden Health Center (address above) or emailed to vaden-emr@stanford.edu

For official use only:

Approved Exemption(s): ____

Denied Exemption(s): ____

Approver Name/Signature: ____

Date: ______________________ 05.06.2021