Health Services provided by Newton Wellesley Collegiate Health

**WELLESLEY COLLEGE**

**REQUEST FOR EXEMPTION FROM IMMUNIZATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(print name), request to be exempt from the Massachusetts and Wellesley College immunization requirement for \_\_\_\_\_\_\_\_\_\_\_\_\_\_(specify vaccine) based on the following:

**□ Religious Grounds:** receipt of immunization would conflict with my sincere religious beliefs

**□ Medical Grounds**: please explain on a separate page

*\*All medical exemptions must be verified with a letter/documentation from a medical provider. It must specify which immunization(s) cannot be given and the condition that prevents the administration of the vaccine. Documentation is subject to review and final decisions to be made by Health Services.*

**I understand the medical risks of forgoing recommended immunizations. I understand that in the event of an outbreak of any of the vaccine-preventable diseases on campus, I may be excluded from campus and classes until the period of communicability has passed. I further understand that Wellesley College will not be responsible for any costs associated with missed classes or exclusion from housing during the period of communicability and that no refund will be made.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**MINORS**: As a parent or guardian for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor (under age 18) enrolled in Wellesley College, I request that said minor be exempt from the Massachusetts immunization requirements as above. I understand the risks of exemption as above.

Parent/Guardian Name and Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

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**□**APPROVED **□**NOT APPROVED

Signature of Medical Director\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_