



**NEWTON-WELLESLEY
HOSPITAL**

2014 Washington Street
Newton, Massachusetts 02462



PATIENT IDENTIFICATION AREA

HEALTH SERVICES PROVIDED BY NEWTON-WELLESLEY COLLEGIATE HEALTH

Immunization Waiver

Student Name: _____ DOB _____ Date _____

Due to my declaration and submission of a Medical/Religious exemption from the immunizations required of Wellesley College students, I _____ have been informed that if there is a suspected or confirmed case of any infectious disease for which there is required immunization, I will be quarantined from classes and/or residence halls for the period of time designated by the Commonwealth of Massachusetts Department of Public Health. I understand that this period of quarantine depends upon the number of identified cases and is at the discretion of the Massachusetts Department of Public Health. I have been provided with a copy of the Massachusetts Department of Public Health Immunization

Exemptions and Vaccine Preventable Disease Exclusion Guidelines in School Settings(
<https://www.mass.gov/files/documents/2018/09/14/guidelines-vaccine-exclusions-school.pdf>)
for my reference.

I fully understand the above information and agree to follow the required quarantine procedures.

Student Signature _____ Date _____

Parent signature _____ Relationship _____

(if student under 18 yo)

Witness signature _____ Dater: _____

Health Services provided by Newton-Wellesley Collegiate Health * 106 Central St. Wellesley, MA
Tel 781-283-2810 * Fax 781-283-3693