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 # __________________________ State of Licensure: __________________________
Licensed as: __________________________

___ 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