REQUEST FOR MEDICAL EXCEPTION FROM ANY VACCINATION

PLEASE PRINT THE FOLLOWING INFORMATION:

Name:_____________________________________
E-mail:_____________________________________
School:_____________________________________
Provider Name:______________________________
Date of Birth:____ /____ / ____
Phone:_____________________________________
Provider Phone:______________________________

Have you ever been granted a medical exception for this vaccine through JHU Student Health? ☐YES ☐NO
f YES, please list years_________________________ (Note: No additional documentation is required)
If NO, please have provider complete below.

Dear Provider:

For the safety of our staff, faculty, medical providers, trainees, students and patients, there are mandatory
vaccination policies in effect across Johns Hopkins University and Medicine. The above named person is requesting
an exception from this vaccination requirement. A medical exception from vaccination is allowed for certain
recognized contraindications.

Please complete the form below. Should you have any questions, please contact Johns Hopkins Student Health and
Wellness Center at 410-516-8270. Thank you.

The above person should NOT be immunized for ________________________________ for the following reasons:

name of vaccine(s)

Please check all that apply and attach supporting DOCUMENTATION or MEDICAL RECORDS.

☐ History of previous allergic reaction and documented allergy testing to indicate an immediate hypersensitivity
reaction to the vaccine or a component of the vaccine.

☐ History of Guillain-Barre Syndrome within six weeks of receiving a previous vaccine. Please provide and attach a
detailed narrative that describes the event.

☐ Other – Please provide this information in a separate narrative that describes the exception in detail (these
requests will be reviewed on a case-by-case basis).

I certify that _________________________________has the above contraindication(s) and request a medical
exception from the following vaccination(s):______________________________________________________

(Patient Name)

Provider Signature:___________________________
(Note: Signature Stamp Not Acceptable)

Date:___ / ____ / ____
Provider License No:___________________

PLEASE FAX, E-MAIL OR MAIL THIS TO THE JHU STUDENT HEALTH & WELLNESS CENTER

1 East 31st Street, N200
Baltimore, MD 21218
Office 410.516.8270 / Fax 410.516.4784
E-mail: healthforms@jhu.edu

DESIGNATED OFFICE USE ONLY:
Medical Exception Approved on: ____/____ / ____ Approving Staff Signature:______________________________

Edited 5/17/2023