



# IMMUNIZATION EXEMPTION FORM - MEDICAL

- State law requires that enrolled students submit their immunization records to Trinity Christian College (TCC) prior to enrollment.
- TCC understands that medical conditions may be present that would put the student at risk, if fully vaccinated.
- A student may be exempt and still be in compliance of Illinois state law if a licensed medical provider provides a medical objection which indicates that an immunization is medically contraindicated.
- The physician must provide the nature and probable duration of the medical condition.
- Please have the clinician complete the first section of this exemption form to be in compliance with state law.
- Student should complete the bottom section of this form and return to Student Life.

## TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER

Name of patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

I, (print name) \_\_\_\_\_ certify that the above-named student is under my medical care and has a medical condition that contraindicates his/her vaccination/s at this time. Select all that apply and probable duration of the medical condition.

DTP (nature and duration of exemption) \_\_\_\_\_

Measles (nature and duration of exemption) \_\_\_\_\_

Rubella (nature and duration of exemption) \_\_\_\_\_

Mumps (nature and duration of exemption) \_\_\_\_\_

Meningococcal Vaccine (nature and duration of exemption) \_\_\_\_\_

Health Care Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Type of clinician \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

## TO BE COMPLETED BY STUDENT

I have provided this form, signed and dated by my licensed health care provider, certifying that receiving the stated vaccinations are contraindicated due to my medical condition. I consent to allow TCC to contact my health care professional to obtain information as it relates to my ability to receive the above vaccine/s. I understand that failure to be fully immunized may result in the need for my removal from the campus should an outbreak of one of the above illnesses occur.

Student signature \_\_\_\_\_ Date \_\_\_\_\_

Parent signature (if under 18) \_\_\_\_\_ Student ID \_\_\_\_\_

## UPLOAD COMPLETED FORM INTO STUDENT PORTAL:

STUDENT LIFE OFFICE  
Phone: 708-239-4704  
Email: studentlife@trnty.edu