UNMC Vaccination Waiver Request

This form must be completed and submitted to Student Health in lieu of or in addition to the Student Immunization form when a student is requesting a waiver of immunization requirements. This form must be accompanied by the Titer results for all required immunization; except Flu.

Waiver Titer Panel
Varicella Zoster IgG
Mumps IgG
Rubeola IgG
Rubella IgG
Hepatitis B Surface AB * if negative will need Hepatitis B Surface AG*
QuantiFERON®-TB Gold test (QFT-G)
Polio (P1, P2, &P3

Student Name: _____

Students DOB: _____

NUID: _____

Email: _____

Reason for requesting Waiver

____ Medical: provide detail of the specific reason _____

_____

Students Physician's signature: _____ Date: _____

____ Religious belief: I attest to the fact that immunization conflicts with the tenets and practice of a recognized religious denomination or with personal and sincerely followed religious belief

I understand that if I am not vaccinated I may be required to wear a mask or use other protective devices such as a gown while in certain patient care areas or certain healthcare facilities. I may or may not be required to pay for these protective devices.

I understand that I am required to remove myself from classrooms and clinical rotations at the first sign of infection/disease. I understand that I may not return until cleared by Student Health. If completion of course requirements is delayed due to my illness, my program of study may need to be modified and my expected graduation date may be delayed.

I understand that I am responsible for informing my clinical supervisors of my vaccination status so that they may assist in determining agency requirements and patient assignments.

I understand that failure to comply with these requirements may result in disciplinary action, up to and including dismissal from the program.

I understand that I may be putting not only myself but also the patients for whom I care at risk for

1) **contracting a serious disease**
2) **suffering negative consequences of the disease (extended hospitalization, loss of a limb)**
3) **possible death**

I affirm that I have read the above information and agree to abide by the requirements of this waiver.

_____ _____
Student's Signature Date

_____ _____
Student Health Director Signature Date

_____ _____
NU ADA Coordinator Signature Date