UNMC Vaccination Waiver Request Form

This form must be completed and submitted to Student Health, accompanied by the baseline immunity results for all required immunizations; except Tdap and Flu.

Student Name: ____________________________
Student DOB: ____________________________
NUID: ____________________________
Email: ____________________________

<table>
<thead>
<tr>
<th>Waiver Titer Panel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella Zoster IgG</td>
</tr>
<tr>
<td>Mumps IgG</td>
</tr>
<tr>
<td>Rubella IgG</td>
</tr>
<tr>
<td>Hepatitis B Surface AB * if negative will need Hepatitis B Surface AG*</td>
</tr>
<tr>
<td>QuantiFERON®-TB Gold test (QFT-G)</td>
</tr>
<tr>
<td>Polio (P1, P2, &amp; P3)</td>
</tr>
</tbody>
</table>

Reason for requesting Waiver

___ Medical: provide detail of the specific reason _____________________________________________________________

__________________________________________________________ Date:

Signature of Provider*:

___ Religious belief: I attest to the fact that immunization conflicts with the tenets and practice of a recognized religious denomination of which I am an adherent or member or that immunization conflicts with my personal and sincerely followed religious beliefs.

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 may be required to excuse myself from a clinical assignment if I do not have immunity to a vaccine-preventable disease and said disease begins to circulate in the community where my clinical rotation is scheduled. In the event I am not able to complete clinical assignments as scheduled, 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 waiver requirements may result in disciplinary action, up to and including dismissal from the program.

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

Student Signature: ____________________________________________ Date: ______________

Signature of Student’s Parent/Guardian, if under 19: ____________________________ Date: ______________

Student Health Director Signature: ____________________________ Date: ______________

UNMC ADA Coordinator Signature: ____________________________ Date: ______________

*Eligible providers defined by R.R.S. Neb. § 79-221.