University of Nebraska Medical Center

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.

Waiver Titer Panel for Medical	
Varicella Zoster IgG	Hepatitis B Surface AB (if negative will need Hepatitis B Surface AG)
Mumps IgG	QuantiFERON®-TB Gold test (QFT-G)
Rubeola IgG	Polio (P1, P3)
Rubella IgG	
Circle if only waiving the following vaccine:	
Flu vaccine	

Name: _____ Date of birth: _____

Student ID number: _____ Email: _____

Reason for Requesting Waiver

☐ Medical
Provide details _____

Physician's print name: _____ NPI #: _____

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.

Religious affiliation: _____

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 measles and measles 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 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 contracting a serious disease, suffering negative consequences of the disease (extended hospitalization, loss of a limb), or 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

_____ _____ _____ _____

Parent/guardian signature (if student is under 19) Date UNMC ADA Coordinator signature Date