CHICAGO STATE UNIVERSITY
1867

WELLNESS/HEALTH CENTER

9501 S. King Drive / ADM 131
Chicago, Illinois 60628-1598
Office: 773 995 2010
Fax: 773 995 2953

IMMUNIZATION EXEMPTION – Religion/Medical

Patient's Name: _____ Identification Number: _____

Address/City/State/Zip _____ Telephone #: _____

In accordance with the College Student Immunization Act, a Chicago State University student may be exempt from applicable immunization requirements as specified in the Act, on religious grounds.

In the space below, please provide a statement detailing your objection to the immunization. The objection must set form the specific religious belief that conflicts with the immunization requirements. Note: Statements of general philosophical or moral reluctance to allow immunizations do not provide a sufficient basis for an exemption on the grounds of religious belief.

I affirm: 1) that the statements made above truly reflect my religious beliefs or practices; 2) that I will hold Chicago State University harmless should I contract a vaccine preventable disease; and; 3) that I will comply with any and all limitations placed upon me by the University or public health officials in the interest of public health should an outbreak of a vaccine preventable disease occur on campus or in the surrounding community.

_____ _____
Signature Date

Submit the completed petition to the Chicago State University Wellness Center

❑ Approved _____Initials
❑ Not Approved _____Date

Exemption Petition Continued

I _____ am aware of the need to comply with Illinois Department of Public Health Part 694 College Immunization code.

I am requesting exemption due to the following:

- ☐ Religious Waiver – Please attach petition and letter by head of religious affiliate on official stationary signed by your religious leader.
- ☐ Medical Waiver – Medical exemption **must** accompany documentation from your primary care provider and/or waived by the Wellness/Health Center
- ☐ Pregnancy – EDC _____
- ☐ Medical Condition _____
- ☐ Enrolled for less than 6 hours in correspondence courses.

Provision of information: I have provided the parent or legal guardian of the student named above, with information regarding 1) the required examinations, 2) the benefits of immunization, and 3) the health risks to the student and to the community from the communicable diseases for which immunization is required in Illinois. I understand that my signature only reflects that this information was provided; I am not affirming the parent or legal guardian's religious beliefs regarding any examination, immunization or immunizing agent.

_____ _____

Signature of Student **Date**

Required Healthcare Provider Verification and Stamp Required		
HEALTH CARE PROVIDER (MD,DO,APN,NP,PA,RN,PLN,PharmD) **VERIFY IMMUNIZATIONS WERE GIVEN**		
Provider Name (print):	Signature and credentials:	Date:
Address (including City/State/Country/Zip or Postal Code):	Phone:	
RELIGIOUS AFFILIATION		
Religious Leader Name (print):	Signature and credentials:	Date:
Religious Organization Affiliation Name (print):		
Address (including City/State/Country/Zip or Postal Code):	Phone:	