



Immunization Exemption-Medical

Student's Name _____
Last Name First Name

Date of Birth _____ Student ID# _____

Address _____
Street City State Zip Code

Healthcare Provider Statement

Nature and probable duration of the medical condition or circumstances that contraindicate the immunization(s), including pregnancy or suspected pregnancy. Identify specific vaccine(s).

Healthcare Provider's Name _____ MD/DO/NP/PA

Signature _____

I accept full responsibility for my health, thus removing liability from The School of the Art Institute of Chicago in regard to the state mandated, compulsory immunizations. Furthermore, I understand that in the event of an outbreak of measles, mumps, rubella, tetanus, diphtheria, pertussis, or meningitis, I will be required to leave the campus if I am not vaccinated against the disease. I understand that if my medical condition or circumstance later permits immunization, the exemption granted shall terminate, and I shall be required to obtain the immunization.

I am at least 18 years of age and enter this request for exemption and waiver as a free and voluntary act.

Student's Signature _____ Date _____

Parent/Guardian signature if student is under age 18

This exemption was approved by the Illinois State Law 105 ILCS 5/27-8.1. This document fulfills the requirements of Section 694.200, subchapter K: Communicable Disease Control and Immunization, IL Administrative Code, in accordance with the Illinois Department of Public Health.