MEDICAL EXEMPTION - VACCINATION REQUIREMENT

Students may exempt for medical reasons*.

Instructions: Complete and sign this form. Your licensed medical provider will complete the bottom section. Upload the completed form to MyBuckMD OR email to vaccination@osu.edu OR fax to 614-292-7042 OR mail to Health Information Services, 1875 Millikin Rd., Columbus, OH 43210

TO BE COMPLETED BY STUDENT

____

Last Name First Name Middle Initial

Date of Birth (mm/dd/yyyy): ____________________ University ID Number (8 or 9 digits):______________________________

I request an exemption for the following vaccines (check all that apply):

- Hepatitis B
- Measles
- Mumps
- Rubella
- Meningococcal Conjugate (ACWY)
- Tetanus/Diphtheria/Pertussis (Tdap)
- Varicella

Student Signature ____ Today's Date ______________

TO BE COMPLETED BY LICENSED MEDICAL PROVIDER (MD, DO, PA, NP, RN, RPh)

Provider Name ____

Provider NPI ____________________ Provider Phone Number ____________________

Provider Signature/Credentials ____ Date ______________

(Office Stamp)

*This form is not valid for students in a health profession program (nursing, dentistry, medicine, etc.). This form is accepted for The Ohio State University Vaccination Requirement only.