WAYNE STATE
College of Nursing

MEDICAL DECLINATION WAIVER/NOTICE OF RISK FOR VACCINATION

Please complete section 1 and submit the form to your healthcare provider for completion of Section 2. Once complete, please upload form to your CastleBranch tracker for review. Please note: Castlebranch will automatically reject this form. Please reach out to the Office of Student Affairs to request approval of this form in the system.

SECTION 1: To Be Completed by Student

Name: _____ Access ID: _____

By signing this document I understand that by declining a vaccine, or being a vaccination non-responder, I continue to be at risk of acquiring an illness. I also confirm that I have discussed with my healthcare provider and understand that a lack of immunity puts myself at risk for contracting the illnesses selected by my healthcare provider below. Please note that you may be excluded from a clinical site due to not having the required vaccinations/immunizations.

Signature: _____ Date: _____

SECTION 2: To Be Completed by Healthcare Provider (Nurse Practitioner or Physician)

The patient is receiving a medical exemption for the following required vaccine(s):

_____ Varicella/Chicken Pox
_____ Measles/Mumps/Rubella
_____ Hepatitis B
_____ Tdap

Reason(s) for waiver:

_____ Pregnancy: Due Date: _____
_____ Breastfeeding
_____ Chronic medical condition
_____ Non-responder - Hepatitis B, Varicella, MMR (please circle)
_____ Tdap:_____ (list reason)
_____ Other (details required):

_____

_____

Exemption Period:

_____ Permanent exemption (for allergy and certain medical conditions)
_____ Temporary exemption; note time frame: _____
**Automatically terminates after one month, if a date is not identified by HCP Details*

Section 2 continued on next page

Section 2 cont.

Hep B Repeat Series Confirmation

- 1st HepB antibody titer quantitative result: _____ mIU/mL
- Dates of 3-dose Hep B repeat series vaccinations:

  Dose-1: _____ Dose-2: _____ Dose-3: _____

- 2nd HepB antibody titer quantitative result: _____ mIU/mL

Confirmation of Medical Exemption

By signing this document, as the healthcare provider, I certify that I have discussed the risks associated with declining a vaccination or being a non-responder with my patient.

Practitioner Signature: _____ Date: _____

Print Name: _____ Title: MD DO NP PA

National Practitioner Identifier #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email Address: _____

For any questions or concerns in regards to this form, please contact the Office of Student Affairs at (313) 577-4082 or nursinginfo@wayne.edu.

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