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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