WAYNE STATE
College of Nursing

MEDICAL DECLINATION FORM
(limited to life-threatening events)

Student to complete and submit to Healthcare provider

Student Name: _____ Date:_____

Access ID: _____ Date of Birth: _____

Select Pathway: ☐ BSN ☐MSN ☐Graduate Certificate ☐DNP ☐PhD

What vaccine are you requesting a life-threatening medical exemption for (select all that apply):

☐Flu ☐Varicella ☐MMR ☐Hep B ☐Tdap

Have you ever had a life-threatening allergic reaction after a vaccine? ☐Yes ☐No

If yes, please provide the manufacturer of the vaccine, approximate date of vaccine administration and a brief description of your allergic reaction_____

_____

_____

Have you ever had a life-threatening allergic reaction to any of the vaccine ingredients? ☐Yes ☐No
If Yes, name(s) of the ingredients: _____
_____

Student Signature: _____ **Date:**_____

Healthcare Provider to Complete

A Michigan-licensed physician/practitioner must complete and sign this request for exemption.

Students who have a life-threatening medical reaction that would prevent them from being able to receive vaccines must submit documentation from their physician/practitioner to the College of Nursing to approve the medical exemption.

Physician/Practitioner Statement: The above-named student of the WSU College of Nursing is under my care. I request the following medical exemption based on a true medical contraindication related to a life-threatening medical reaction.

Permanent Exemption related to: _____

☐Severe allergic reaction (e.g. anaphylaxis)

☐ History of anaphylactic reaction to vaccine ingredient:

Please indicate vaccine manufacturer(s) you are exempting student from:

Print Provider Name: _____ **MI Medical License #** _____
Address: _____ **Phone**: _____
Signature:_____ **Date**: _____

Student Instructions: email completed form to: conclinicals@wayne.edu for processing

College of Nursing Program Director Use only

☐Approved ☐ Not Approved

Print Name: _____ **Signature**: _____**Date**:_____
College of Nursing Program Director