College of the Holy Cross Health Services
One College Street
Worcester, MA
01610-2395
508-793-2276 Fax 508-793-3610

MEDICAL/RELIGIOUS EXEMPTION

Student Name _____ Date of Birth _____
(Print last, first name)

Immunization Exemptions: I request that the above named student be exempt from the vaccine(s) checked below:

☐ Hepatitis B ☐ Td/Tdap ☐ Varicella ☐ MMR ☐ Meningitis ☐ Influenza

I have received and read the educational materials explaining the disease(s) and vaccine(s) checked above and:

Initials	I understand the benefits and the risks of the vaccine(s)
Initials	I understand the risk of contracting the disease(s) that the vaccine(s) prevent.
Initials	I understand the risk of transmitting the disease(s) to others.
Initials	I understand that, if an outbreak of vaccine preventable disease should occur, an exempt student will be excluded from class and/or the residence halls for a period of time to be determined by the MA Department of Public Health (104 CMR 300.00).

Philosophical exemptions are not allowed by law in Massachusetts.

This exemption is for _____ Religious or _____ Medical Reasons.

If Medical exemption, Health Services requires documentation from a healthcare provider.

I understand that I will be asked annually to submit in writing, my immunization status.

Signature of student (over age 18): _____ Date: _____

Signature of parent or guardian (under age 18): _____