BELMONT
COLLEGE

Medical Vaccine Exemption Acknowledgement Form

Student Name: _____

Healthcare Program: _____

TO BE COMPLETED BY A HEATHCARE PROVIDER:
Please indicate the vaccination(s) exemption requested:

☐Influenza ☐Tdap ☐Hepatitis-B ☐Varicella ☐MMR ☐ COVID-19

N95 mask quantitive fit testing is required for all exemptions.

Please explain the reason a medical exemption from this vaccine is necessary:

_____
_____
_____
_____
_____
_____
_____
_____
_____

EXAMINING HEALTHCARE PROVIDER'S INFORMATION:

Name (please print) _____

Address: _____

Phone Number: _____

Signature: _____ Date: _____

(continued)

Student Name: _____

Healthcare Program: _____

BOXES TO BE INITIALED BY STUDENT:

	I understand and assume the risks of non-vaccination. I accept full responsibility for my health, and the risk of serious illness, including death, due to non-vaccination, and release Belmont College from any and all responsibility and liability.
	I have reviewed the VIS (vaccine information statement) for applicable vaccine(s), available at https://www.cdc.gov/vaccines/hcp/vis/index.html
	I understand that clinical sites require the vaccine(s) indicated, and that I must complete the clinical experience in order to satisfy the course requirements for my program. I understand that if the exemption request is approved, clinical placement cannot be guaranteed, which may prevent me from completing the program.
	Because I am not vaccinated, in order to protect my own health and the health of the community, I will comply with all applicable testing and other preventative health and safety measures issued by Belmont College or the clinical site. I will incur all costs associated with these guidelines. I understand that these vary by facility and may not be available at the time of exemption request.
	I understand that, if approved, this exemption is based on the current program policy and is subject to change based on the requirements moving forward or upon new healthcare guidelines.
	I understand that if I become ill or my clinical experience is limited as a result of being unvaccinated, I will not be excused from meeting the objectives of the course and/or clinical experience.
	I understand that, if approved, this exemption will remain in effect through the duration of the current academic year. Students will reapply for exemptions each academic year or upon reinstatement or change of program.
	I certify that the information I have provided on and in connection with this form is accurate and complete. I understand this exemption may be revoked and I may be subject to disciplinary action, up to and including dismissal from the program, if any of the information I have provided on or in connection with this from is false.

Student Signature: _____ Date: _____

Phone Number: _____ Email: _____

All completed paperwork is to be returned to the healthcare program at least three weeks prior to the beginning of a clinical experience for which an exemption is required.

TO BE COMPLETED BY COLLEGE REPRESENTATIVE:

☐Approved

☐Not approved

Name (please print) _____ Role: _____

Signature: _____ D _____