Westchester Community College
State University of New York

Measles, Mumps & Rubella Vaccination Requirement
Medical Exemption Request Form

To request a medical exemption from the WCC Measles, Mumps & Rubella Vaccination requirement, please complete this form and submit it to the Health Services Office (Student Center 181; healthoffice@sunywcc.edu). A decision regarding your request will be released through email.

Part I. Student Information and Certification:

LAST NAME	FIRST NAME	STUDENT EMAIL ADDRESS
DATE OF BIRTH	STUDENT ID #	[redacted]

Please check each box to acknowledge:

☐ I understand that in the event a measles, mumps or rubella outbreak should occur on-campus I may be required to remain off-campus until the Westchester County Department of Health deems it safe to return. I am aware that if I am enrolled in courses that require a physical presence on campus that I may not be able to complete my academic coursework remotely. I acknowledge that any refund I might be entitled to in the case of a MEASLES, MUMPS & RUBELLA outbreak would be subject to all existing WCC policies.

☐ I certify that I have confirmed with my academic program that not receiving the MEASLES, MUMPS & RUBELLA Vaccination will not prevent the completion of my programmatic or curricular requirements.

☐ I certify that my statements above, and all supporting documentation, are true and accurate, and that the receipt of the MEASLES, MUMPS & RUBELLA vaccination may be detrimental to my health.

Signature*: _____ Date: _____
*Student, but Parent or Legal Guardian must sign if the student is under 18 years old as of first day of classes.

Please note that the campus reserves the right to request additional documentation to support a request for a medical exemption.

Part II. Medical Exemption Request (to be completed by medical provider)

A licensed medical provider (Physician, Physician's Assistant, or Nurse Practitioner) and student should review information regarding contraindications for MEASLES, MUMPS & RUBELLA vaccines. The provider must complete Section(s) A and/or B and provide their provider information in Section C.

Section A. Medical Provider Certification of Contraindication: I certify that my patient (named above) cannot be vaccinated against MEASLES, MUMPS & RUBELLA because of the following contraindication:

_____

_____

_____

_____

_____

_____

_____

_____

Clinician Certification: **By completing this form, you certify that different methods of vaccinating against MEASLES, MUMPS & RUBELLA have been fully considered and that the patient has the contraindication indicated above that precludes any/all available vaccinations for MEASLES, MUMPS & RUBELLA.**

Section B. Medical Provider Certification of Disability That Makes MEASLES, MUMPS & RUBELLA Vaccination Inadvisable

"Disability" is defined as any impairment resulting from anatomical, physiological, genetic, or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques and any other condition recognized as a disability under applicable law.

"Disability" may include pregnancy, childbirth, or a related medical condition where reasonable accommodation is medically advisable.

I certify that my patient (named above) has the following disability that makes MEASLES, MUMPS & RUBELLA Vaccination inadvisable: _____

Additional details on why the disability listed above makes MEASLES, MUMPS & RUBELLA Vaccination Inadvisable (to be completed by the medical provider):

_____

_____

_____

The patient's disability is: ☐ Permanent
☐ Temporary

If temporary, the expected end date is: _____

Section C. Medical Provider Information

Provider Name: _____

Provider National Provider Identifier (NPI): _____

Provider Specialty: _____

Provider Employer/Affiliation: _____

Provider Phone: _____

Provider Signature: _____ Date of signature: _____