

# Immunization Waiver--Southeast Community College Health Sciences

Student Name: \_\_\_\_\_ SCC ID# \_\_\_\_\_ Date Received: \_\_\_\_\_

**MEDICAL WAIVER:** For students who are not immunized for medical reasons, please have a medical provider complete and sign this form; or a provider may submit a separate, signed document that specifies the immunization(s) and reason(s) for the medical waiver. You must attach any such document to this form. Then, the student (or, if under age 19, the student's parent or guardian) must sign this waiver before a notary and return this form to the college during the application period for the desired program of study.

I do not have the following immunizations that are required by our clinical partners:

- |                                                               |                                                         |
|---------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Measles/Rubella, Mumps, Rubella      | <input type="checkbox"/> DSARS-CoV-2 (COVID-19)         |
| <input type="checkbox"/> Hepatitis B                          | <input type="checkbox"/> Varicella-Zoster (Chicken Pox) |
| <input type="checkbox"/> TDap: Pertussis, Diphtheria, Tetanus | <input type="checkbox"/> Influenza (flu shot-seasonal)  |

**Reason for Medical Waiver:** \_\_\_\_\_

**In the event of an outbreak of a communicable disease or request of clinical partners, unimmunized students may be excluded from clinical by our clinical partner.**

Date \_\_\_\_\_ Medical Provider's Signature \_\_\_\_\_

*(Required)*

Print Medical Provider's Name \_\_\_\_\_

*(Required)*

Date \_\_\_\_\_ Student/Parent/Guardian Signature \_\_\_\_\_

*(Required)*

**RELIGIOUS WAIVER:** If immunization conflicts with religious beliefs and convictions, the student must present this form AND **a notarized statement from religious leadership** indicating the reason the immunization(s) conflict(s) with your religious practice or belief. You must present both documents to the college during the application period for the desired program of study.

I, \_\_\_\_\_, attest that because of my religion, I do not have the following immunizations that are required by our clinical partners:

Check appropriate boxes:

- |                                                               |                                                         |
|---------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Measles/Rubella, Mumps, Rubella      | <input type="checkbox"/> DSARS-CoV-2 (COVID-19)         |
| <input type="checkbox"/> Hepatitis B                          | <input type="checkbox"/> Varicella-Zoster (Chicken Pox) |
| <input type="checkbox"/> TDap: Pertussis, Diphtheria, Tetanus | <input type="checkbox"/> Influenza (flu shot-seasonal)  |

Because such immunizations: (Check if a true statement)

- Conflicts with the practice of a recognized religious denomination of which the student is an adherent or member or that immunization conflicts with personally and sincerely followed religious beliefs of a student.

**In the event of an outbreak of a communicable disease or request of clinical partners, unimmunized students may be excluded from clinical by our clinical partner.**

Date \_\_\_\_\_ Student/Parent/Guardian Signature \_\_\_\_\_

*(Required)*

STATE OF NEBRASKA )  
 ) SS.  
COUNTY OF \_\_\_\_\_)

The foregoing instrument was acknowledged before me this \_\_\_ day of \_\_\_\_\_, 20\_\_ by \_\_\_\_\_

\_\_\_\_\_  
**Notary Public**

**Please submit to the SCC Health Sciences Division (healthsciences@southeast.edu)**