



BACTERIAL MENINGITIS IMMUNIZATION MEDICAL EXEMPTION AFFIDAVIT

As the physician of:

_____	_____
Student's Last Name	First Name
____ / ____ / _____	_____
Date of Birth	EMPLID/Student ID #

This student has not been immunized against Bacterial Meningitis based on the conclusion at this time that it would be injurious to the student's health.

Comments:

_____	_____
Physician's Name	Physician's Signature

Physician's Address

____ / ____ / _____

Date