



## Student Vaccination Exemption Request

Nebraska Wesleyan University currently requires the following vaccines for students:

Coronavirus vaccine	all students
2 MMR (measles-mumps-rubella)	all full-time traditional undergraduates
At least one meningococcal vaccine at or over the age of 16 (may be first or second meningitis vaccination)	All full-time traditional undergraduates who matriculate before their 24th birthday.

Vaccinations are important to the health and safety of the NWU community. The risk of contagious diseases includes others on campus, not only the unvaccinated individual. Only documented medical or religious exemptions from the required vaccinations are allowed.

To request an exemption, the student should submit this either the Request for Medical Exemption or the Request for Religious Exemption along with the appropriate documentation to [studenthealth@nebrwesleyan.edu](mailto:studenthealth@nebrwesleyan.edu). Requests will be reviewed by the Director of Student Health and the Vice President for Student Life.

## Request for Medical Exemption from Required Vaccinations

*Please complete BOTH sections of the following:*

### 1) TO BE COMPLETED BY STUDENT

Immunization Requirements subject to exemption request: (Please indicate):

All     COVID-19     2 MMR     Meningococcal

I, the undersigned Nebraska Wesleyan University student, object to the immunization requirement(s) marked above and request a medical exemption as supported by my medical provider.

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Student Signature Signed	DOB	Student ID#	Date
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Student Name (Printed)	Address	City/State ZIP	Phone
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### 2) TO BE COMPLETED BY MEDICAL PROVIDER

This section is to be completed and signed by a licensed medical professional, (M.D., D.O., PA-C, or APRN), who is or who works in the same practice as the student's primary care provider, and documents the provider's professional opinion that a required immunization would be harmful to the student or would pose risk to someone within the student's household.

*In my opinion the required immunization(s) marked above would be harmful to the student or would pose a risk to someone within the student's household.*

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Practitioner Signature	License #	Date Signed
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Practitioner Name (Printed)	Address	City/State ZIP	Phone
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