

## Immunization Medical Exemption Form

Student completing this information:

Last Name	First Name	Date of Birth	S#	Student Email
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Parent/Guardian completing this form if student is under 18 years old:

Last Name:	First Name:	Relationship to Student:
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A medical exemption may be granted to any student who has a documented medical condition that prevents them from receiving the immunizations listed below. **This form must be signed by a medical provider.** Please submit this form to Brooke Lucero, Career and Disability Services Coordinator at [brooke.lucero@trinidadstate.edu](mailto:brooke.lucero@trinidadstate.edu). Medical exemptions need to be filed only once unless the student's information changes.

Students with a recorded immunization exemption may be kept off the College campus during a disease outbreak; the length of time will vary depending on the type of the disease and the circumstances of the outbreak, and alternative attendance options (e.g., online coursework) will be utilized when available.

### Required Vaccines:

Check Vaccine Declined	List medical contraindications for each vaccine declined
<input type="checkbox"/> Measles, Mumps, Rubella: Two valid doses of Measles, Mumps and Rubella (MMR) vaccine are required for students born on or after January 1, 1957. Measles can cause infection, pneumonia, encephalitis, and death. For more information: <a href="https://www.cdc.gov/measles/vaccination.html">https://www.cdc.gov/measles/vaccination.html</a>	
<input type="checkbox"/> SARS-CoV-2 (COVID-19): Vaccine is required as a condition of living in the College residence halls and/or participating on a College athletic team. COVID-19 can cause difficulty breathing, loss of taste or smell, body aches, and death. For more information: <a href="https://www.cdc.gov/coronavirus/2019-ncov/vaccines/keythingstoknow.html">https://www.cdc.gov/coronavirus/2019-ncov/vaccines/keythingstoknow.html</a>	

**Statement of Exemption**

The physical condition of the above named student is such that vaccination would endanger their life or health or is medically contraindicated due to other medical conditions. The information I have provided on this form is complete and accurate.

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**Required Physician Signature**

\_\_\_\_\_  
**Date**

Physician (MD, DO), Advanced Practice Nurse (APN), or Physician Assistant (authorized pursuant to section 12-240-107 (6), C.R.S.)

Under Colorado law, you have the option to exclude your information from the Colorado Immunization Information System (CIIS). To opt out of CIIS, go to: [www.colorado.gov/cdphe/ciis-opt-out-procedures](http://www.colorado.gov/cdphe/ciis-opt-out-procedures). Please be advised that you will be responsible for maintaining your immunization records to ensure school compliance.