



## IMMUNIZATION CONSCIENTIOUS/RELIGIOUS/MEDICAL FORM

### PLEASE PRINT

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*Last First Middle Month Day Year*

### CONSCIENTIOUS / RELIGIOUS

#### ***MUST BE NOTARIZED***

**MUST FILL OUT IF UNABLE TO MEET REQUIRED IMMUNIZATIONS DUE TO CONSCIENTIOUS OR RELIGIOUS BELIEF.**

*I do not wish to receive the required vaccine(s) for reasons of conscience, and I voluntarily agree to release, discharge, indemnify and hold harmless Gustavus Adolphus College, its officers, trustees, employees, and agents from any and all costs and liabilities, expenses, claims, demands or causes of action on account of any loss or personal injury that might result from my waiver of the recommended vaccination. I also assume responsibility for any transmission of the disease to others, should I become infected. I have read and signed this document with full knowledge of its significance.*

*I hereby certify by notarization that my conscientious or religious belief is opposed to immunizations.*

.....  
*Student Signature (or parent or legal guardian if under 18 years of age).*

.....  
*Date*

### MEDICAL EXEMPTION

**MUST BE COMPLETED IF UNABLE TO MEET REQUIRED IMMUNIZATIONS DUE TO MEDICAL CONTRAINDICATIONS.**

*The physical condition of the above named person is such that the vaccine(s) would endanger life or health, or is medically contraindicated due to other medical conditions.*

.....  
*Signature of Medical Professional (MD, DO, CNP, PA-C)*

.....  
*Date*

**PRINT MEDICAL PROFESSIONAL'S NAME AND ADDRESS OR AFFIX MEDICAL STAMP HERE:**