Salt Lake Community College

Certificate of Exemption—Personal/Religious

Last Name:	First Name:	Middle Initial:	Birthdate (mm/dd/yyyy):

Personal/Philosophical or Religious Exemption

I am exempting myself from the requirement to be vaccinated against the following disease(s) to attend school. (Select an exemption type and the vaccinations you wish to be exempt from):

PERSONAL/PHILOSOPHICAL EXEMPTION*

- ☐ Diphtheria
- ☐ Hepatitis B
- ☐ Hib
- ☐ Influenza
- ☐ Pneumococcal
- ☐ Polio
- ☐ Pertussis (whooping cough)
- ☐ Tetanus
- ☐ Varicella (chickenpox)

Measles, mumps, or rubella may not be exempted for personal/philosophical reasons per state law

RELIGIOUS EXEMPTION

- ☐ Diphtheria
- ☐ Hepatitis B
- ☐ Hib
- ☐ Influenza
- ☐ Polio
- ☐ Pertussis (whooping cough)
- ☐ Tetanus
- ☐ Pneumococcal
- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Varicella (chickenpox)

Declaration

One or more of the required vaccines are in conflict with my personal, philosophical, or religious beliefs. I have discussed the benefits and risks of immunizations with the health care practitioner (signed below). I have discussed the benefits and risks of immunizations with the health care practitioner granting this exemption. I understand that failure to immunize may result in the inability to be placed at clinical sites, which would also preclude me from completing required clinical coursework.

______________________________ Name (print)

______________________________ Signature

______________________________ Date

Health Care Practitioner Declaration

I have discussed the benefits and risks of immunizations with the patient as a condition for exemption. I certify I am a qualified MD, ND, DO, ARNP, or PA licensed in Utah.

______________________________ Licensed Health Care Practitioner Name (print)

______________________________ Licensed Health Care Practitioner Signature

______________________________ Date

☐ MD ☐ ND ☐ DO ☐ ARNP ☐ PA

Utah License #____________________

Religious Membership Exemption

Complete this section ONLY if you belong to a church or religion that objects to the use of medical treatment. Use the section above if you have a religious objection to vaccinations but the beliefs or teachings of your church or religion allow for you to be treated by medical professionals such as doctors and nurses.

Declaration

I am a member of a church or religion whose teaching does not allow health care practitioners to give medical treatment. I understand that failure to immunize may result in the inability to be placed at clinical sites, which would also preclude me from completing required clinical coursework.

Name of church or religion of which you are a member:

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______________________________ Name (print)

______________________________ Signature

______________________________ Date