



Student Vaccine Exemption

Harvard University Health Services
Health Information Services
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Questions? Harvard Medical & Dental – P: (617) 432-1370 F: (617) 432-7120
Harvard Law School – P: (617) 495-4414 F: (617) 495-8090
All other schools – Email: mrecords@huhs.harvard.edu

I, _____ am a student at Harvard University and request that I be exempt from the requirement to receive the following vaccinations (Massachusetts Department of Public Health, 105 CMR 220.600 - 700):

All Hepatitis B MMR Varicella Tdap Flu COVID-19 Other: _____

I request that I be exempt from the requirement to receive the above vaccinations and immunizations based on:

Recent Covid Illness Date of Onset: _____ Note: Temporary exemption will expire 3 months after date of onset

Medical grounds. *Please explain:*

Note: All medical exemptions **must be verified with a letter from the student’s medical provider**, in addition to completing this form. It must specify which immunization(s) cannot be given and certify that the provider has personally examined the student and is of the opinion that the student’s health would be endangered by the immunization.

Religious grounds. I certify that the receipt of a vaccine or immunization would conflict with or violate my sincere religious beliefs.

- **I understand and agree that in the event of an outbreak of a communicable disease**, I will (at my own expense) either leave campus or receive an immunization for the communicable disease and will follow Harvard's policies and protocols as well as the recommendations of the local board of public health related to the communicable disease.
- I further understand and agree that when one or more cases of a vaccine-preventable disease or any other communicable disease are present on campus or in Harvard's geographical area, I may be subject to isolation or quarantine in accordance with the Massachusetts Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements (105 CMR 300.000) and Harvard policies and protocols.

Student Name (please print)

Date of Birth (month/day/year)

Student Signature

Date (month/day/year)*

Local/ Campus Address

HUID

City, State, Zip Code

Upload completed Exemption Form and letter from your medical provider, if required, to the Patient Portal (<https://huhs.harvard.edu/patient-portal>)

Note: The Massachusetts Department of Public Health **requires this waiver to be renewed annually.**

* Waiver expires one year from date of signature.