



# healthyhorns

University Health Services

# Measles Medical Exemption

Texas Administrative Code Title 25, Part 1, Chapter 97, Subchapter B, Rule § 97.62: Exclusions from compliance are allowable on an individual basis for medical contraindications, reasons of conscience, including a religious belief, and active duty with the armed forces of the United States. Children and students in these categories must submit evidence for exclusion from compliance as specified in the Health and Safety Code, §161.004(d), Health and Safety Code, §161.0041, Education Code, Chapter 38, Education Code, Chapter 51, and the Human Resources Code, Chapter 42.

- (a) To claim an exclusion for medical reasons, the child or student must present an exemption statement to the school or child-care facility, dated and signed by a physician (M.D. or D.O.), properly licensed and in good standing in any state in the United States who has examined the child or student. The statement must state that, in the physician's opinion, the vaccine required is medically contraindicated or poses a significant risk to the health and well-being of the child or student or any member of the child's or student's household. Unless it is written in the statement that a lifelong condition exists, the exemption statement is valid for only one year from the date signed by the physician.

## Instructions for completing and submitting the form:

1. Print and complete the form by hand.
2. Photograph or scan the completed form.
3. Log in to the Med+Proctor portal using your UT EID and password.
4. Submit the completed form.

## SECTION A: To Be Completed by the Student

STUDENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_ UT EID \_\_\_\_\_

PHONE \_\_\_\_\_

## SECTION B: To Be Completed by the Healthcare Provider

\_\_\_ In my opinion, the required vaccination (measles) would be injurious to the health and well-being of this student.

This exemption:

\_\_\_ is permanent.      \_\_\_ expires on: \_\_\_\_\_.

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PHYSICIAN NAME

\_\_\_\_\_  
PHYSICIAN ADDRESS

\_\_\_\_\_  
PHYSICIAN PHONE NUMBER

(OPTIONAL) PHYSICIAN OR PRACTICE'S STAMP