

For UHS office use only.

COVID-19 Vaccine Exemption Declaration

Date: _____ Initials: _____



Nicholls State University

COVID-19 Vaccination Exemption Declaration

Louisiana R.S. 17:170 - Schools of Higher Learning

University Health Services • P.O. Box 2054, Thibodaux, LA 70310

Phone: 985.493.2600 • Fax: 985.493.2601 • Email: healthservices@nicholls.edu

Name: _____ Date of Birth: _____

Nicholls ID Number: _____ Semester Enrollment: _____

Nicholls E-mail Address: _____ Phone: (_____) _____

I am requesting an exemption from the COVID-19 vaccination(s) and I am aware of the risks.

Reason for COVID-19 vaccination exemption declaration:

Medical

Physician's statement required.

Religious

Statement required below.

Philosophical

Statement required below.

Understand the Risks and Responsibilities

Pursuant to Louisiana R.S. 17:170: In the event of an outbreak of a vaccine-preventable disease at Nicholls State University, the administrators are empowered, upon the recommendations of the Office of Public Health to exclude from attendance unimmunized students until the appropriate disease incubation period has expired or the unimmunized person presents evidence of immunization.

By signing below, I understand that if I claim exemption for medical, religious, or philosophical reasons, I may be excluded from campus and from classes in the event of an outbreak of COVID-19 until the outbreak is over or until I submit proof of immunizations. I understand that if I decline the required vaccinations, I continue to be at risk for serious disease. I can always receive the vaccine(s) at any time. I have read and understand the vaccine information from the Centers for Disease Control and Prevention and understand risks and responsibilities in exempting/waiving the required immunizations.

Nursing and Allied Health Students only:

Consent for UHS to release my information to my clinical coordinator and/or clinical site.

Student Signature: _____ **Date:** _____

If student is not 18 years of age, legal guardian must sign below.

Parent or Guardian Signature (*if required): _____ **Date:** _____

Please submit completed form to UHS by fax-(985) 493-2601, e-mail-healthservices@nicholls.edu, or upload it to the Patient Portal at nicholls.medicatconnect.com. You can also bring it to the UHS office in Ayo Hall.