ST MARY'S COLLEGE of MARYLAND
The National Public Honors College

Student Vaccination Exemption Form

DUE: August 1st (Fall admission)
December 15th (Spring Admission)

St Mary's College of Maryland requires vaccination against Meningococcal and Covid-19.
To request an exemption, please complete **Section 1** and **Section 2** and/or **Section 3**. Section 3 requires the certification and signature of a medical provider. This exemption expires one (1) year from the date signed. Once signed and completed, upload to your SMCM Health Record.

Section 1

Student Legal Name: _____ Date: ___/___/_____

Date of Birth: ___/___/_____ Cell Phone: _____ Residential Student or Commuter: _____
Reason for Exemption:
☐ Religious – Complete Section 2 ☐ Medical – Complete Section 3

Section 2 - Vaccination Exemption for Religious Reasons

I am requesting a religious exemption from the SMCM vaccination requirement to be vaccinated against:
(Check all that apply)
☐ Meningococcal Vaccine
☐ Covid-19 Vaccine

I certify that my religious beliefs are true and verify that the information I am submitting above is true and accurate to the best of my knowledge.

Student Signature: _____ Date: ___/___/_____

Parent/Guardian Signature: _____ Date: ___/___/_____
If student is a minor (under 18 years of age), a parent/guardian signature is required.

Section 3 - Vaccination Exemption for Medical Reasons
To be Completed by Student

I am requesting a medical exemption from the SMCM vaccination requirement to be vaccinated against:
(Check all that apply)
☐ Meningococcal Vaccine
☐ Covid-19 Vaccine

I verify that the information I am submitting is true and accurate to the best of my knowledge

Student Signature: _____ Date: ___/___/_____

Parent/Guardian Signature: _____ Date: ___/___/_____
If student is a minor (under 18 years of age), a parent/guardian signature is required.

Section 3 - Continued
To be Completed by Provider

It is my medical opinion that the above student should not be immunized for the aforementioned vaccine(s) due to the following reason(s):

_____

_____

I certify that _____ has the above medical contraindication to the vaccine(s) mentioned above and request a medical exemption for this student. Unless stated, this exemption will expire one (1) year from the date signed.

Provider Address: _____ Phone: _____

_____

Provider Name: _____

*Provider Signature: _____ Date: ___/___/_____
*Stamp not accepted