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VACCINE WAIVER FORM

Name of Member ____ **Date of Birth** ________________

Hepatitis B, Tetanus, Diphtheria or Varicella Waiver:

To be completed by Member: I understand that due to my participation in clinical activities, I may be an increased risk of being exposed to blood-borne and other potentially infectious materials and may therefore be at risk of acquiring diseases such as Hepatitis B Virus (HBV), Tetanus, Diphtheria, Varicella, Mumps or other infections. I know that I have the option of being vaccinated at a medical facility of my own choosing, or any another facility recommended by AmeriClerkships at my expense, but I do not wish to be vaccinated at this time. I understand that by declining vaccination(s), I continue to be at risk of acquiring serious diseases associated with such infectious agents and I accept full responsibility for this, holding AmeriClerkships, its affiliate physicians and healthcare facilities, business associates, employees and any other associated organization harmless. If in the future I continue to participate in activities with exposure to blood or other potentially infectious materials and I want to be vaccinated, I can receive the vaccination series at my expense. I am requesting to be waived from vaccination against (check all that apply):

☐ **Hepatitis B Virus** ☐ **Tetanus** ☐ **Diphtheria** ☐ **Varicella**

Member Signature ______________________________________ **Date** ________________

Mumps Waiver (requires completion and signatures by BOTH the Member and Healthcare Provider):

1. **To be completed by Member:** I am not eligible to receive the MMR or MMRV vaccine or have not developed immunity to Mumps, and I understand my risk and responsibility. I hereby release, hold harmless, and agree to indemnify AmeriClerkships Medical Society, its staff, and clinical sites from any and all responsibility or consequences which may result from my lack of immunity to the Mumps vaccine. I have read the U.S. Centers for Disease Control and Prevention's MMR VACCINE – WHAT YOU NEED TO KNOW. Further, I understand that my lack of immunity to the Mumps virus may result in the refusal of a clinical placement based on individual clinical partnership contracts. I am requesting to be waived from the following:

   ☐ **Mumps**

   Member Signature ______________________________ **Date** ________________

2. **To be completed by Healthcare Provider (HCP):** The individual named above is not eligible to receive MMR or MMRV vaccine or has no positive titer to the virus because he/she (must select at least one):

   ☐ Has a a life-threatening allergy to the antibiotic neomycin
   ☐ Has a life-threatening allergy to any component of the MMR or MMRV vaccine
   ☐ Has a pervious history of __________________________________ reactions to the MMR or MMRV vaccine
   ☐ Is receiving immunosuppressive drug therapy
   ☐ (She) Is pregnant
   ☐ Has cancer
   ☐ Has a history of low platelet count
   ☐ Has recently received a transfusion or other blood products
   ☐ Has received two MMR or MMRV vaccinations, each followed by negative titers for Mumps
   ☐ Has received the MMR or MMRV vaccine as a child, and also a recent booster on _______________

   HCP Signature ________________________________ **Date** ________________

   HCP Name ____________________________________ **Office Stamp**

Last Revised: 12/18/2015