California State University San Bernardino
Department of Nursing

Declination to Further Immunization

I have received a minimum of two immunizations and two negative titers and hereby decline to receive further re-immunizations of the following:

- ☐ Rubella
- ☐ Rubeola
- ☐ Mumps
- ☐ Varicella
- ☐ Hepatitis B

Print Name SID Number Date

Student's Signature

Health care provider's statement of contraindication to immunization: _____
Specify Immunization

- ☐ Failure to convert
- ☐ Allergies – Specify: _____
- ☐ Currently pregnant – Due Date: _____
- ☐ Other – Please Specify: _____

Health Care Provider verifying information (THIS FORM MUST BE SIGNED BY A HEALTHCARE PROVIDER): Nurse Practitioner, Physician, Registered Nurse, Physician's Assistant or a public health official:

Name of Healthcare Provider (Print) Telephone (area code + number)

Signature of Health Care Provider Date

Address of Health Care Provider

04/09 LG