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: __________________________________________________________

☐ 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