healthyhorns

University Health Services

Measles Medical Exemption
Allergy, Immuniations and Travel Clinic

Texas Administrative Code Title 25, Part 1, Chapter 97, Subchapter B, Rule § 97.62: Exclusions from compliance are allowable on an individual basis for medical contraindications, reasons of conscience, including a religious belief, and active duty with the armed forces of the United States. Children and students in these categories must submit evidence for exclusion from compliance as specified in the Health and Safety Code, §161.004(d), Health and Safety Code, §161.0041, Education Code, Chapter 38, Education Code, Chapter 51, and the Human Resources Code, Chapter 42.

(1) To claim an exclusion for medical reasons, the child or student must present an exemption statement to the school or child-care facility, dated and signed by a physician (M.D. or D.O.), properly licensed and in good standing in any state in the United States who has examined the child or student. The statement must state that, in the physician's opinion, the vaccine required is medically contraindicated or poses a significant risk to the health and well-being of the child or student or any member of the child's or student's household. Unless it is written in the statement that a lifelong condition exists, the exemption statement is valid for only one year from the date signed by the physician.

IMPORTANT: The document must be printed and completed by hand, photographhed, or scanned to be uploaded.

INSTRUCTIONS ON HOW TO UPLOAD FILE:

1. Log into your **MyUHS** patient portal with your UT EID and password.
2. Click on **Medical Clearances**. Then click on the **Update** button for Measles.
3. Enter the date your provider signed this document under **Administered Date.**
4. Navigate to **Immunization Upload** to submit this document.

IMPORTANT: Only one upload is allowed. After upload, your submission will be processed in the order it was received.

SECTION A: This section should be completed by the student:

Last Name: _____ First Name: _____

UT EID: _____ Date of Birth: ___/___/___ (Month / Day / Year)

Telephone: _____ Email Address: _____

SECTION B: This section should be completed by the health care provider:

☐ ***In my opinion, the required vaccination (Measles) would be injurious to the health and well-being of this student.***

This exemption:

☐ Is permanent ☐ Expires on: ___/___/___ (Month / Day / Year)

Physician Signature: _____ Date: ___/___/___ (Month / Day / Year)

Physician Name (please print): _____ (Last Name / First Name)

Physician Address: _____ (Address / City / State / Zip Code)

Physician Phone Number: _____

(OPTIONAL) PHYSICIAN OR PRACTICE'S STAMP