

**VACCINATION EXEMPTION REQUEST FORM**  
**(for Vaccinations NOT required by the State of Hawaii)**

Name: \_\_\_\_\_ HPU ID: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

HPU Degree Program: \_\_\_\_\_

HPU Clinical Placement Director: \_\_\_\_\_

I hereby request an exemption from the Vaccination Requirements for the degree program named above based on the following grounds

Medical Exemption: The above named student has the following contraindication(s) that prevent the student from receiving their vaccinations

In making this request, I understand and acknowledge the following (initial each statement)

\_\_\_\_\_ (I) The requirements for each clinical placement are set by the clinical facility and not HPU. Therefore, HPU cannot guarantee whether the clinical facility will approve an exemption or permit a clinical placement for a student who does not meet all requirements of that facility. Submission of these forms, even if accepted or approved by HPU, DO NOT mean that the clinical facility will accept, consider or approve a request for exemption.

\_\_\_\_\_ (II) Notwithstanding any exemption approved by HPU, the facility, hospital, or provider may prohibit placement and/or restrict access to the facility for students that are not fully vaccinated.

\_\_\_\_\_ (III) The clinical practicum provider may accept evidence of an exemption issued by HPU or it may require that I satisfy the provider's process in order to request an exemption. I am fully responsible for complying with any special provider or facility requirements at my own cost.

\_\_\_\_\_ (IV) If the facility does allow for exemptions for some or all vaccination requirements, understand that I must comply on my own time and at my own cost, with any facility requirements for additional testing, special equipment, or other mitigation measures. In addition, the facility may later withdraw its approval, with or without prior notice to me and HPU.

\_\_\_\_\_ (V) Despite the above, HPU may be unable to locate a suitable clinical practicum site willing to offer the required practicum experience needed for successful completion of my degree program without vaccination. In such case, I acknowledge and agree that I will be unable to complete the clinical experience course required for my program, as well as certain licensing requirements, and these programmatic requirements cannot be modified and will not be able to be met without this inpatient clinical practicum experience.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Parent/Guardian Signature if under 18 years of age

**INTAKE AND REVIEW BY HPU**