

IMMUNIZATION WAIVER

I, the undersigned, hereby waive the requirement for (please print):

Last name	First Name	Middle Initial
University. I agree to hold O	nizations required by the State of Ohio and thio Dominican University harmless in the compliance with their requirement for in	ne event of any illness or
The immunizations I have ch	nosen to WAIVE include (please list):	
	ound on the Immunization Record located in the	Housing Packet.
Student Name: (please print	t clearly)	
Last name	First Name	Middle Initial
Student Signature:		Date:
Date of Birth:	(mm/dd/yyyy)	
*Parent/Guardian Signature: *If student is under the age of 18.		Date:

Please return this form along with the Health Insurance & Medical History form, Immunization form, Meningococcal and Hepatitis B Vaccination Status form to:

Ohio Dominican University Health Services 1216 Sunbury Road Columbus, Ohio 43219

If you have any questions, please feel free to call (614) 251-4709 or email dudleyb@ohiodominican.edu.