



VACCINATION EXEMPTION REQUEST FORM
(for Vaccinations NOT required by the State of Hawai'i)

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 for the following period of time:

Medical Provider Signature: _____ Date: _____

Please attach contact information for the medical provider, including business name and address and attach additional forms, as needed.

Religious Exemption: I certify that I am unable to fulfill the Vaccination Requirements as the immunization conflicts with my sincerely held religious beliefs, tenets, practices or observance. Feel free to describe further below or attach additional support:

Please attach the HPU Request for Religious Exemption Form, if this Religious Exemption applies to immunizations required by the State of Hawai'i. The form is available at:

<https://www.hpu.edu/registrar/health-clearance.html>

In making this request, I understand and acknowledge the following (please 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, does 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, I 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/or HPU.

_____ (V) Despite the above, HPU may be unable to locate a suitable clinical practicum provider that is 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 courses 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:

Received By (Print Name): _____ Date: _____

Signature: _____

REQUEST APPROVED

Signature of Reviewer/Approver: _____

Print Name: _____

Date of Notification: _____

REQUEST DENIED OR ADDITIONAL INFORMATION REQUIRED

Signature of Reviewer/Approver: _____

Print Name: _____

Date of Notification: _____

Additional Information Required by []: _____

Additional Information Received By: _____ Date: _____

Signature of Reviewer/Approver: _____

Print Name: _____

Date of Notification: _____

REQUEST APPROVED

REQUEST DENIED