

Bacterial Meningitis Medical Exemption

_____/_____/_____
Student Last Name Student First Name Date of Birth

900_____
Student ID# _____@udallas.edu _____-_____-_____
Student Email Address Student Phone Number

Return completed form/documentation to:
University of Dallas
School of Ministry Admissions Office
1845 E. Northgate Drive
Irving, TX 75062
Fax: 972-721-4009

Medical Exemption Information

The required vaccination would be injurious to the health and well being of the patient. Please select the appropriate box below:

Permanent Medical Exemption

_____/_____/_____
Today's Date

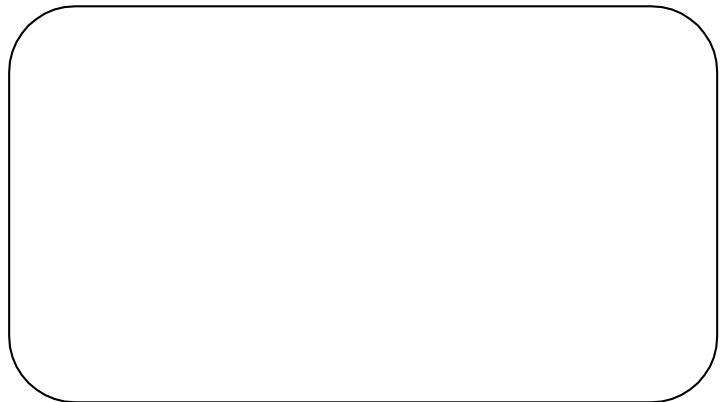
One-year Medical Exemption

Physician Printed Name

Physician Signature

_____/_____/_____
Date Signed

Practice/Hospital Name



Physician/Practice Stamp