UNIVERSITY OF SAN FRANCISCO
School of Nursing and Health Professions

Varicella Vaccine Waiver

Part 1: To be completed by the student

Last Name: _____ First Name: _____

ID Number: _____ USF E-mail: _____

I have been given the opportunity to be vaccinated with the Varicella vaccine and wish to declare the following as cause for my exemption, by checking "yes" to the applicable statement:

Part 2: To be completed by the Healthcare Provider

Questions	*Yes*	*No*
1. Does the student have a life-threatening allergy to the antibiotic neomycin?		
2. Does the student have a life-threatening allergy to gelatin?		
3. Does the student have a life-threatening allergy to any component of the vaccine?		
4. Does the student have pervious history of adverse reactions to the Varicella vaccine? *Please specify:* _____/_____/_____		
5. Is the student receiving immunosuppressive drug therapy?		
6. Is the student pregnant?		
7. Does the student have any kind of cancer?		
8. Is the student being treated for cancer with radiation or drugs?		
9. The student has received his/her first Varicella vaccination series followed by a negative titer for Varicella. The student has received his/her second Varicella vaccination series followed by a second negative titer for Varicella.		

IF YOU ANSWERED YES TO ANY OF QUESTIONS 1 THRU 9, PROCEED TO WAIVER OF VACCINE SECTION.

WAIVER OF VACCINATION

WAIVER OF VACCINE – Complete if not eligible to receive vaccine or have no positive titer to the virus.

□ I am not eligible to receive the Varicella vaccination series based on my medical history (questions 1-8).

□ I have received two Varicella vaccination series and have *not* developed a positive titer to Varicella.

I am not eligible to receive the Varicella vaccination series or have not developed immunity to Varicella, and I understand my risk and responsibility. I hereby release, hold harmless, and agree to indemnify the University of San Francisco, its staff, and clinical sites from any and all responsibility or consequences which may result from my lack of immunity to the Varicella vaccine. I can access a copy, CHICKENPOX VACCINE – WHAT YOU NEED TO KNOW, a vaccine information statement developed by the U.S. Department of Health and Human Services (Centers for Disease Control and Prevention) for detailed information regarding this virus. Further, I understand that my lack of immunity to the Varicella virus may result in the refusal of a clinical placement based on individual clinical partnership contracts.

Student Signature: _____

Date: _____/_____/_____

Healthcare Provider's Signature

Name: _____ Certification: MD / NP / PA / RN

HCP Signature: _____

(Office Stamp)

Date: _____/_____/_____