Certificate Of Medical Exemption

Name Of Student ______________________________ Birthdate ______________

Name Of Parent ____

Address ____

(Street) (City) (State) (Zip)

Medical Exemption - A medical exemption from vaccination for the above named individual is hereby recommended on the basis of the following specific condition which is a medically recognized contraindication to the administration of the required vaccines.

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Vaccines Contraindicated

		DTaP	DT-Ped.	Td-Adult	IPV	Measles	Mumps		Rubella	Hep B
Permanently	( )	( )	( )	( )	( )	( )	( )	( )	( )	
Temporarily	( )	_____ (until date)	_____ (until date)	_____ (until date)	_____ (until date)	_____ (until date)	_____ (until date)	_____ (until date)	_____ (until date)	

____ ______________

Physician/Health Provider Date

Address ____

(Street) (City) (State) (Zip)

Telephone Number ______________

Accepted by Local Health Officer: ______________________________ ______________

(Signature) (Date)

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<u>School Officials:</u> DO NOT file this form in the cumulative folder. This form MUST be maintained in a separate file and reviewed periodically to insure validity.