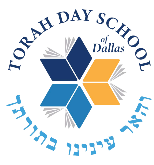

Immunization Requirements for School Attendance
Medical Exemption Statement

Instructions:

1. Complete information (name, DOB etc.).
2. Indicate which vaccine(s) the medical exemption is referring to.
3. Complete contraindication/precaution information.
4. Complete date exemption ends, if applicable.
5. Complete medical provider information. Retain copy for file. Return original to facility or person requesting form.

1. Patient's Name ______________________________
2. Patient's Date of Birth ______________________________
3. Patient's Address ______________________________
4. Name of Educational Institution ______________________________

Guidance for medical exemptions for vaccination can be obtained from the contraindications, indications, and precautions described in the vaccine manufacturers' package insert and by the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP) available in the Centers for Disease Control and Prevention publication, Guide to Vaccine Contraindications and Precautions. This guide can be found at the following website: **http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm**.

Based on the Centers for Disease Control and Prevention publication, Guide to Vaccine Contraindications and Precautions, I recommend a medical exemption for the below vaccines:
Signature: ______________________________

- ☐ Haemophilus Influenzae type b (Hib)
- ☐ Polio (IPV or OPV)
- ☐ Hepatitis B (Hep B)
- ☐ Tetanus, Diphtheria, Pertussis (DTaP, DTP, Tdap)
- ☐ Measles, Mumps, and Rubella (MMR)
- ☐ Varicella (Chickenpox)
- ☐ Pneumococcal Conjugate Vaccine (PCV)
- ☐ Meningococcal Vaccine (MenACWY)

Please provide a detailed reason for each exemption: ______________________________

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Unless specified that it is a lifelong condition exists, the exemption statement is valid for only one year from the date signed by the physician. Is it a lifelong condition?

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A licensed physician must complete this medical exemption statement and provide their information below:

Name (print) ______________________________ State License # ______________

Address ______________________________

______________________________ Telephone ______________

Signature ______________________________ Date ______________

For Institution Use ONLY: Medical Exemption Status ☐ Accepted ☐ Not Accepted Date: ______________