

Medical Exemption from Immunization Requirement/s

Date: _____

Patient Name: _____ Date of Birth: _____
(Please PRINT Full name) (mm/dd/yyyy)

School Name: _____

Address: _____

On _____ I, the undersigned physician, examined the Patient named above.
Date

Based on my examination, it is my professional judgment that the Patient named above will face serious health risk(s) - which are checked below - **if the Patient receives the following named vaccination/s.**

Generic name/s of the Vaccine(s) that the named patient should not receive: _____

Identify Serious Health Risk(s): (Please check one)

The Patient has the following allergy to the vaccination(s) listed above _____ and will suffer the following severe allergic reaction if the Patient receives the vaccination: _____

I have diagnosed the Patient with the following immunodeficiency: _____ and if the Patient receives the vaccination the Patient will face the following serious health risk: _____

I have diagnosed Patient with the following neurological disorder: _____ and if the Patient receives the vaccination the Patient will face the following serious health risk: _____

Please check accordingly:

Valid for school year: _____ - _____ (this exemption will be valid for one school year)

This is to be a lifelong medical exemption from the Vaccine/s listed above.

It is also my judgment that admitting the Patient to the School named above will pose no serious health risk to the rest of the school community, children, or staff.

MD/DO Signature:	MD/DO License #
Printed Name:	Phone:
Date of Patient Exam:	Address: City, State Zip:

*****IMPORTANT: This entire sheet may be faxed as long as the cover sheet is from doctors/clinic office letterhead. The physician may attach additional information for explanation.**