Health Services

Return directly to:
Health Services

Office Use Only
Re: _______________
Ap: _______________
Ac: _______________

Medical Exemption to Immunization

Must be completed and signed by a licensed physician/nurse practitioner.

Name:____ Date of Birth:____

Address:____

Name of parent/guardian:____
(If under 18 years of age)

The above named individual has an exemption to receiving the vaccine indicated below (check all that apply):

This is a:

_______ Permanent exemption due to severe/life threatening reactions.

_______ Temporary exemption due to ____
(Specify patients condition ex. Pregnancy)

This temporary exemption extends to _______________________ after which the vaccine may be given.
(Date)

Appointment date to have the immunization:____

☐ M.M.R (Measles , Mumps, Rubella)

☐ Tetanus-Diphtheria

☐ Polio

☐ Varicella

☐ Hepatitis

☐ Influenza

☐ Meningococcal

☐ Other: ___________________________________

Healthcare providers name and title (please print):____

Signature:____

Address: ____

Phone #:____ Registration # and State:____