Date: _____

Name of Patient: _____ Age of Patient: _____

Name of School: _____

Address of School: _____

_____

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

Based on my examination, it is my judgment that the Patient will face the following *serious* health risk(s) if the Patient receives the following vaccination(s).

Identify Vaccination(s): _____

_____.

Identify Serious Health Risk(s):

- ☐ 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 the Patient with the following neurological disorder: _____ _____and if the Patient receives the vaccination the Patient will face the following serious health risk: _____ _____.
- ☐ Valid for school year: _____
- ☐ Lifelong medical exemption/professional opinion of physician: _____ _____.

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.

_____
(Signature of Physician)

Printed Name: _____

MEDICAL EXEMPTION FROM IMMUNIZATION REQUIREMENTS. This statement is to be copied or typed on the physician's letterhead and signed by the physician. The physician may attach additional sheets for further explanation.

Approved: October 2010