

Medical Certificate of Immunization Exemption

Name I	Last: F	irst:	Middle:	Date of Birth:
The ab	ove named applicant qualifies for a medical	exemption to immu	nization for the following reas	son (select one):
	In the opinion of a physician, nurse practitioner, or physician assistant the following required immunization(s) would be injurious to the health and well-being of the applicant or any member of the applicant's family or household (contraindication due to contact with family or household member applies only to MMR and Varicella vaccine). Select only those vaccines which are medically contraindicated:			
	☐ Hepatitis B (Hep B)	☐ haemophilu	is influenzae type b (Hib)	☐ Varicella (Chickenpox)
	☐ Diphtheria, Tetanus, Pertussis (DTaF	P) 🗆 Pneumocoo	ccal (PCV)	☐ Tetanus, Diphtheria, Pertussis (Tdap)
	☐ Polio (IPV)	☐ Measles, R	ubella (MMR)	☐ Meningococcal (MenACWY)
	If, in the opinion of the physician, nurse practitioner, or physician assistant issuing the medical exemption, the exemption should be terminated or reviewed at a future date, an expiration date shall be recorded on the Certificate of Immunization Exemption.			
	Administration of the following required vaccine(s) would violate minimum interval spacing of at least 28 days from a dose of a previously received live vaccine. In this circumstance, the exemption shall apply only to an applicant who has not received prior doses of exempted vaccine. An expiration date, not to exceed 60 days, shall be recorded on the certificate. Check only the immunizations which are medically contraindicated:			
	☐ Measles, Rubella (MMR)	☐ Varicella (C	Chickenpox)	
Certific	ate Expiration Date:			
exclude range f	granted a medical exemption may be excluded from child care or school will vary depend rom several days to over a month. A Certific d physician, nurse practitioner, or physician	ing on the type of di ate of Immunization	sease and the circumstance	s surrounding the outbreak, and could
	edical Exemption shall be submitted by the a of the school or licensed child care center in			olicant's parent or guardian to the admitting
	ing this certificate, I certify the immunization applicant's family or household, or the require			
Name ((Print): Physician (MD or DO), Physician Ass	istant, or Nurse Pra	lowa Medical Lictitioner	cense Number:
Signatu	ure:Physician (MD or DO) Physician Assista	ant or Nurse Practit	Date:	