Medical Exemption from Immunization Request Form

Instructions: This form must be completed by a licensed medical provider (MD, DO, NP, or PA) to request a medical exemption from immunization requirements. Please print and complete all sections.

Section 1: Patient / Student Information

Full Name: _____

Date of Birth (MM/DD/YYYY): _____

Address: _____

Phone Number: _____

School, Childcare, or Institution Name: _____

Section 2: Medical Provider Information

Provider Name: _____

Medical Title (MD, DO, NP, PA): _____

State License Number: _____

Clinic/Facility Name: _____

Phone Number: _____

Email Address: _____

Section 3: Medical Exemption Details

Please list the specific vaccine(s) that are contraindicated for this patient:

Exempted Vaccine(s) (e.g., MMR, DTaP, Varicella, Influenza):
_____

Please describe the medical contraindication or precaution that prevents immunization (refer to CDC guidelines):

Medical Reason / Diagnosis: _____

Indicate if this medical exemption is temporary or permanent:

Exemption Type (Enter "Temporary" or "Permanent"): _____

If temporary, specify expiration date (MM/DD/YYYY): _____

Section 4: Signatures and Certification

By signing below, I certify that the immunization(s) listed above are medically contraindicated for this patient in accordance with standard medical practice guidelines.

Medical Provider Signature: _____ Date: _____

By signing below, I acknowledge that I am requesting this medical exemption for myself or my child/dependent, and understand that in the event of an outbreak, the exempted individual may be excluded from school, childcare, or work for safety reasons.

Parent/Guardian or Patient Signature: _____ Date: _____