STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

MEDICAL

Student Name___________________________ Student ID#_________________

I, _________________________________, hereby certify that the administration of

(Physician)

the following vaccine(s) or other immunizing agents are contraindicated by the physical
condition of the above named student such that immunizations would endanger life or
health:

☐ Diphtheria       ☐ Measles
☐ Tetanus          ☐ Mumps
☐ Pertussis        ☐ Rubella
☐ Polio            ☐ Hepatitis
☐ Varicella        ☐ Meningococcal
☐ Other: specify ______________

Reason for contraindication:

How long is/are immunizing agent(s) medically contraindicated? ______________

________________________________________ Physician's Signature and Stamp