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 ________________

________________________________________ Physician’s Signature and Stamp