

MEDICAL EXEMPTION

Student Name: _____ Date of Birth: _____

Parent / Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: (Home) _____ (Work) _____

Name of School _____ Grade _____

MEDICAL EXEMPTION: As specified in the code of Virginia § 22.1-271.2 C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____ DTP/DT/P
_____ OPV/IVP
_____ HBV
_____ Mumps
_____ Varicella

_____ DT/Td
_____ Hib
_____ Measles
_____ Rubella
_____ Other: _____

This contraindication is permanent: _____, or temporary _____ and expected to preclude immunizations until: Date: ___ / ___ / ___ (Month, Day, Year).

Physician Signature

Physician - Typed or Printed

Address

Telephone

Fax

Date