Medical Exemption to Required Immunizations

Optional Form for Licensed Physicians (MD or DO only)

STUDENT NAME (Last, First, Middle)	DATE OF BIRTH / /

Exemption Due to Physical Condition or Medical Circumstance

I certify that the child has a physical condition or medical circumstance such that immunization otherwise required for admission to school, child care center, day nursery, nursery school, family day care home, or development center in California is not considered safe. I understand that, for the protection of the child and other students, the child may be excluded from attending school for prolonged periods during outbreaks or exposure to disease for which immunization has not been completed. (17 CCR §6060).

Immunizations Included in Exemption:

Immunization	Duration of physical condition or medical circumstance
☐ Polio	☐ Temporary until date: _____ ☐ Permanent
☐ DTaP	☐ Temporary until date: _____ ☐ Permanent
☐ MMR	☐ Temporary until date: _____ ☐ Permanent
☐ HIB	☐ Temporary until date: _____ ☐ Permanent
☐ Hepatitis B	☐ Temporary until date: _____ ☐ Permanent
☐ Varicella	☐ Temporary until date: _____ ☐ Permanent
☐ Tdap	☐ Temporary until date: _____ ☐ Permanent

Comments or additional information:

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Licensed physician's name, address, and telephone number:

Signature: _____MD / DO

License Number: _____

Date: _____

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