MSAD 49

Fairfield • Albion • Benton • Clinton

MEDICAL IMMUNIZATION EXEMPTION FORM

School _____ School Year _____

Student Name: _____ Grade _____ Date of Birth _____

BOTH SECTIONS OF THIS FORM MUST BE COMPLETED.

THIS FORM MUST BE UPDATED EACH SCHOOL YEAR.

TO BE COMPLETED AND SIGNED BY STUDENT'S MEDICAL PROVIDER:

As a medical provider of the above named student, I am requesting a waiver for the following immunizations due to a medical exemption:

- ☐ All required immunizations

Specific immunizations:

- ☐ DTAP
- ☐ I/OPV
- ☐ MMR
- ☐ Varicella

The medical reason for immunization exemption is as follows:

_____

_____

_____

_____

Medical Provider Signature: _____ Date: _____

Medical Provider Printed Name: _____ Phone #: _____

TO BE READ AND SIGNED BY PARENT/GUARDIAN:

I understand that in the case of an outbreak of the specific disease(s) for which my child is not protected, my child will be kept out of school and school activities. The length of time my child will be kept out of school may vary from a week to over a month depending on the disease and length of the outbreak. I also understand that if my child is kept out of school, the school is not required to provide off-site classes or tutoring. The school may make reasonable accommodations to assist my child in keeping up with classwork.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____ Relationship to student: _____