MEDICAL EXEMPTION

Student Name: _____ Birth Date:_____

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: [___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; HBV:[___]; Measles:[___]; Mumps:[___]; Rubella:[___]; Varicella:[___]

This contraindication is permanent: [___], or temporary [___] and expected to preclude immunizations until: Date (mo., Day, Yr.): ___/___/___.

Signature of Physician/Health Care Provider:_____
Physician/Health Care Provider's name: _____
(printed)
Address: _____
_____

Telephone: _____ Fax:_____

Date (Mo., Day, Yr.): ___/___/___