IMMUNIZATION MEDICAL EXEMPTION

Date: _____

Date of Birth: _____

Patient Name: _____

First MI Last

I, the undersigned physician, have examined the child named above and it is my medical opinion that the vaccines checked below pose a significant risk to the health and well-being of the patient. I hereby request that this child be exempted due to their medical condition for which immunizations are medically contraindicated.

- ☐ **PCV/PCV13Hib** (Pneumococcal conjugate)
- ☐ **Hib** (Haemophilus inf. type b)
- ☐ **DTaP/DTP/DT** (Diphtheria, Tetanus, Pertussis)
- ☐ **Polio** (IPV)
- ☐ **Tdap/Td** (Tetanus Diphtheria, Pertussis)
- ☐ **HepB** (Hepatitis B)
- ☐ **HepA** (Hepatitis A)
- ☐ **MMR** (Measles, Mumps, Rubella)
- ☐ **Varicella** (Chicken Pox)
- ☐ **Meningococcal** (MCV4, MPSV4)

The duration of this medical exemption is:

- ☐ Temporary exemption (requires an annual renewal)
- ☐ Life-long exemption (No renewal required as long as the physician is authorized to practice in the state of Texas)

_____ (M.D. or D.O. practicing in Texas)

Physician Signature

_____

Physician Name Physician Texas Medical License Number

_____

PHYSICIAN ADDRESS CITY STATE ZIP

_____

PHYSICIAN PHONE

PHYSICIAN STAMP HERE

SCHOOL PERSONNEL ONLY BELOW THE DOTTED LINE

Verification Date: _____ Verification Time: _____ AM PM

Catholic School Nurse or Health Coordinator Name: _____