Kaufman Independent School District
PREPARATION ★ PURPOSE ★ PRIDE

Medical Exemption from Immunizations

STUDENT NAME: _____ DOB: _____

SCHOOL: _____ GRADE: _____

I am a physician (MD or DO), duly registered and licensed to practice medicine in the United States, who has examined the above named child.

It is my opinion that the vaccine required is medically contraindicated or poses a significant risk to the health and well-being of the child or any member of the child's household due to:

_____

Please check only one:

☐ This is a lifelong condition and therefore a lifelong exemption.

☐ This is not a lifelong condition and is valid for one calendar year from date signed. (25TAC §97.62).

Please indicate the vaccine that the child is medically exempt from:

☐ **DTaP/DT/Tdap/Td**	☐ **Hepatitis A**
☐ **Polio**	☐ **Hepatitis B**
☐ **MMR**	☐ **HIB**
☐ **Varicella**	☐ **Pneumococcal**
☐ **Meningococcal**	

_____ _____ _____ _____

(Physician Signature) **(Print Name)** **(Date)** **(Phone)**