

# MSAD 49

ALBION ♦ BENTON ♦ CLINTON ♦ FAIRFIELD

## MEDICAL IMMUNIZATION EXEMPTION FORM

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

Tdap (before entering 7<sup>th</sup> grade)

MCV4

The medical reason for immunization exemption is as follows:

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Medical Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Provider Printed Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

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### 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 \_\_\_\_\_