

Medical Exemption to Required Immunizations

Optional Form for Licensed Physicians (MD or DO only)

STUDENT NAME (Last, First, Middle)	DATE OF BIRTH / /
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Exemption due to Physical Condition or Medical Circumstance

I certify that the child has a physical condition or medical condition such that immunization otherwise required for admission to school, child care center, day nursery, nursery school, family day care home, or developmental center in California is not considered safe. I understand that, for the protection of the child and other students, the child may be excluded from attending school for prolonged periods during outbreaks or exposure to disease for which immunizations has not been completed. (17 CCR §6060).

Immunizations Included in Exemption:

Immunization	Duration of physical condition or medical circumstance
<input type="checkbox"/> Polio	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary until date: _____
<input type="checkbox"/> DTap (Tdap or Td if age 7 or older)	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary until date: _____
<input type="checkbox"/> MMR	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary until date: _____
<input type="checkbox"/> HIB (child care/preschool only)	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary until date: _____
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary until date: _____
<input type="checkbox"/> Varicella	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary until date: _____
<input type="checkbox"/> Tdap (for 7 th -12 th grade)	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary until date: _____

Comments or additional information:

Licensed physician's name, address, and telephone number

Signature: _____ MD/DO

License Number: _____

Date: _____

Medical Exemptions to School-Required Immunizations Questionnaire

In an effort to learn more about medical exemptions (MEs), Marin Health & Human Services kindly requests your assistance to help us collect information about the new medical exemptions being submitted at your schools.

We ask that going forward, please complete a brief questionnaire for each NEW medical exemption you receive.

If you have any questions, please contact Danielle Hiser at Marin Health & Human Services at 415-473-3078 or dhiser@marincounty.org.

* Required

School District & School: *

Choose

What grade level is the student entering? *

Choose

What school year is the student entering? *

- 2015-2016
- 2016-2017
- 2017-2018

What type of medical exemption is it?

- The provider used a Medical Exemption form.
- The provider sent an individualized letter.
- Other :

What is the date that the medical exemption was written by the physician?

MM DD YYYY
/ / 2016

Is this a temporary or permanent medical exemption?

- Temporary Exemption
- Permanent Exemption
-



Not Specified

Which of the following required vaccines are being exempted?
(Please select all that apply.)

- Diphtheria, tetanus, and pertussis vaccines (DTP/DTaP/Tdap/Td)
- Varicella vaccine (VAR)
- Measles, mumps, and rubella vaccine (MMR)
- Polio vaccine (OPV/IPV)
- Hepatitis B vaccine (HBV)

Which of the following other non-required vaccines are being exempted?

- None
- Haemophilus Influenzae Type B vaccine (Hib)
- Hepatitis A vaccine (HAV)
- Human Papillomavirus vaccine (HPV)
- Influenza/Flu vaccine (IIV/LAIV)
- Meningococcal vaccine
- Other:

What is the reason for the medical exemption? (Please select all that apply.)

- The student has a medical condition or health circumstance that prohibits vaccination (ie. immunocompromised).
- The student has a history of adverse reactions to vaccines.
- Proven immunity by history of disease.
- Proven immunity by titer.
- The student has a family history of vaccine reactions.
- Reason is not documented.
- Other:

What is the name of the health care provider?

Your answer

What clinic or practice does the health care provider belong to?

Your answer

What is the city and state or country of the health care provider?

Your answer



Did the student have a PBE (Personal Belief Exemption) previously?

- Yes
- No
- Unknown
- Not eligible (ie. Child could not have had a PBE before, such as a Kindergartener who did not attend child care.)

Please write any other comments about this medical exemption.

Your answer

Any suggestions to improve this survey or data collection process?

Your answer

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