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MEDICAL EXEMPTION

_____ Permanent Exemption

_____ Temporary Exemption

STUDENT INFORMATION			
Student Last Name:	First Name:	MI:	Date of birth:
Parent/Guardian Last Name:	First Name:	MI:	
Street Address	City:	State:	Zip Code:

The above named student has specific health or physical conditions which are recognized contraindications to the administration of one or more of the required vaccines.

Vaccine(s) Contraindicated: _____

Physician Signature

Date

Name and address of Office or Licensed Healthcare Facility