



Los Angeles Unified School District

Student Health & Human Services

Medical Exemption to Required Immunizations

Licensed Physicians (MD or DO only)

STUDENT NAME (Last, First, Middle):		BIRTHDATE:	
SCHOOL NAME	SCHOOL YEAR:	GRADE:	SEX:

Exemption Due to Physical Condition or Medical Circumstance

I certify that the child has a physical condition or medical circumstance such that immunization otherwise required for admission to school, child care center, day nursery, nursery school, family day care home, or development 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 immunization 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"/> Temporary until date: _____ <input type="checkbox"/> Permanent
<input type="checkbox"/> DTaP	<input type="checkbox"/> Temporary until date: _____ <input type="checkbox"/> Permanent
<input type="checkbox"/> MMR	<input type="checkbox"/> Temporary until date: _____ <input type="checkbox"/> Permanent
<input type="checkbox"/> HIB	<input type="checkbox"/> Temporary until date: _____ <input type="checkbox"/> Permanent
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Temporary until date: _____ <input type="checkbox"/> Permanent
<input type="checkbox"/> Varicella	<input type="checkbox"/> Temporary until date: _____ <input type="checkbox"/> Permanent
<input type="checkbox"/> Tdap	<input type="checkbox"/> Temporary until date: _____ <input type="checkbox"/> Permanent

Indicate the specific nature and probable duration of the medical condition or circumstances, that student shall be exempt from the requirements of recommended immunization:

Licensed physician's name, address, and telephone number:

Signature: _____ MD/DO

License Number: _____

Date: _____

Reviewed By: _____

School Nurse Name (Print)
School Nurse Signature
Date

Please Note: For School Nurse ONLY -- File Original in Students' CUM; Attach copy to Welligent