COMMONWEALTH OF KENTUCKY

CERTIFICATE OF MEDICAL EXEMPTION

Name of Child_____ **Birthdate**_____
(Last) (First) (Middle)

Name of Parent or Guardian_____

Address_____
(Street) (City) (State) (Zip Code)

MEDICAL EXEMPTION – THE ABOVE NAMED CHILD HAS CERTAIN SPECIFIC HEALTH/PHYSICAL CONDITIONS WHICH ARE RECOGNIZED CONTRAINDICATIONS TO THE ADMINISTRATION OF ONE OR MORE OF THE REQUIRED VACCINES:

VACCINE(S) CONTRAINDICATED_____

DATES ADMINISTERED (month/day/year)

DIPHTHERIA, TETANUS, PERTUSSIS* **#1____/____/____ #2____/____/____ #3____/____/____ #4____/____/____ #5____/____/____**

POLIO VACCINES **#1____/____/____ #2____/____/____ #3____/____/____ #4____/____/____**

MMR (Measles, Mumps, Rubella)** **#1____/____/____ #2____/____/____ _____ ____/____/____ _____ ____/____/____**
Other Other

Hib*** **#1____/____/____ #2____/____/____ #3____/____/____ #4____/____/____**

Hepatitis B** #1___/___/___#2___/___/___#3___/___/___ or #1___/___/___ #2___/__/___ (adult dose)**
Varicella*** #1___/___/___ or child has had chickenpox disease (X) _____.**

*DTaP, DTP, DT, Td **MMR for one dose, measles-containing for second. ***Hib not required at age 5 years or more. **** Alternative two dose series of approved adult hepatitis B vaccine for children 11-15 years of age. *****Varicella required for children 19 months to 7 years unless a parent, guardian or physician states that the child has had chickenpox disease. This child is current for immunizations until ____/____/____, (two weeks after next shot is due) after which this certificate is no longer valid and a new certificate must be obtained.

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.
Signature of physician, Health Dept., or their designee_____**Date**_____
This Certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record. **EPID-230B (Rev 8/2002)**