Medical Exemption from Immunization Requirement/s

Date: _____

Patient Name: _____ Date of Birth: _____
(Please PRINT Full name) (mm/dd/yyyy)

School Name: _____

Address: _____

On _____ I, the undersigned physician, examined the Patient named above.
Date

Based on my examination, it is my professional judgment that the Patient named above will face *serious* health risk(s) - which are checked below - **if the Patient receives the following named vaccination/s.**

Generic name/s of the Vaccine(s) that the named patient should not receive: _____

_____

Identify Serious Health Risk(s): (Please check one)

- ❑ The Patient has the following allergy to the vaccination(s) listed above _____ _____ and will suffer the following severe allergic reaction if the Patient receives the vaccination: _____
- ❑ I have diagnosed the Patient with the following immunodeficiency: _____ _____ and if the Patient receives the vaccination the Patient will face the following serious health risk: _____
- ❑ I have diagnosed Patient with the following neurological disorder: _____ _____ Patient receives the vaccination the Patient will face the following serious health risk: _____

Please check accordingly:

- ❑ Valid for school year: _____ - _____ (this exemption will be valid for one school year)
- ❑ This is to be a lifelong medical exemption from the Vaccine/s listed above.
- ❑ It is also my judgment that admitting the Patient to the School named above will pose no serious health risk to the rest of the school community, children, or staff.

Texas MD/DO Signature:	Texas MD/DO License #
Printed Name:	Phone:
Date of Patient Exam:	Address: City, State Zip:

***This completed form must be approved by the Diocese of Austin.**
*** Licensed physician (MD or DO) must be authorized to practice in the state of Texas.**

Adopted: 06/08; Revised: 05/10, 04/13,07/15, 06/16, 6/26