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
☐ Polio	☐ Temporary until date: _____ ☐ Permanent
☐ DTaP	☐ Temporary until date: _____ ☐ Permanent
☐ MMR	☐ Temporary until date: _____ ☐ Permanent
☐ HIB	☐ Temporary until date: _____ ☐ Permanent
☐ Hepatitis B	☐ Temporary until date: _____ ☐ Permanent
☐ Varicella	☐ Temporary until date: _____ ☐ Permanent
☐ Tdap	☐ Temporary until date: _____ ☐ Permanent

Indicate the specific nature and probable duration of the medical condition or cirmumstances, 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

Adapted from, ***Optional Form of the American Academy of Pediatrics, California and California Academy of Family Physicians/August 2016***