MEDICAL EXEMPTION FORM

As the physician for ______________________________, I certify that the child has a medical condition that will not permit the child to be immunized to the extent required by Nevada statutes. (Check the appropriate box):

☐ This medical exemption is for all immunizations.

☐ This medical exemption is for one immunization. (i.e. live virus vaccines)
List immunizations included in this exemption.

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☐ This medical exemption is temporary. (i.e. pregnancy, long-term illness, immunocompromised condition of child or household member)
Duration of temporary exemption ______________________________________

I hereby request that this child be exempted from the Nevada Revised Statutes due to a medical condition for which immunizations are contraindicated.

______________________________ ______________________________
Name of Licensed Physician (PRINT) Signature of Licensed Physician

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Date

I understand that if an event of a vaccine-preventable disease occurs for which this child is exempted, the child for whom this exemption is excluded is to be excluded from the school or early childhood program for the duration of the outbreak and/or threat of exposure. My child will be allowed back only when a health department representative is satisfied that there is no longer a risk of contracting or transmitting a vaccine-preventable disease.

______________________________ ______________________________
Name of Child Exempted (PRINT) Child's Date of Birth

______________________________ ______________________________
Name of Parent/Guardian (PRINT) Signature of Parent/Guardian

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Date