KANSAS CERTIFICATE OF IMMUNIZATIONS - FORM B
MEDICAL EXEMPTION

Student Name:__________________________________________ Birthdate: ___________

Street Address:______________________________________________

City:________________________ State:______ Zip Code:__________

Parent/Guardian: ___________________________________________

Telephone: ________________________________

Medical exemption for the following vaccine(s):
( ) DTaP/DT ( ) Hepatitis A
( ) Tdap/Td ( ) Hepatitis B
( ) Pertussis Only ( ) Pneumococcal Conjugate
( ) Polio ( ) Meningococcal Conjugate
( ) MMR ( ) Varicella
( ) Hib ( ) Human Papillomavirus
( ) Rotavirus ( ) Other: ________________________________

I certify the physical condition of this child to be such that the inoculation(s) specified on this form would seriously endanger the life or health of this child.

Signature:________________________________________ Date: ______________

PLEASE PRINT

Name: ____________________________________________

Street Address: ______________________________________

City:________________________________________ State:______ Zip Code:__________

Telephone: ________________________________

Medical License Number:____________________________ State of Licensure: ______

A Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) must complete this affidavit. Annual medical exemptions shall be documented on this form and attached to the student’s Kansas Certificate of Immunizations (KCI) form. Annual medical exemptions must be completed for as long as the medical exemption is warranted.

Rev. 1/30/2020