

**KANSAS CERTIFICATE OF IMMUNIZATIONS - FORM B  
MEDICAL EXEMPTION**

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Telephone: \_\_\_\_\_

Medical exemption due to \_\_\_\_\_

For the following vaccine(s):

- |   |  |
|---|--|
| <input type="checkbox"/> DTaP/DT        | <input type="checkbox"/> Hepatitis A             |
| <input type="checkbox"/> Tdap/Td        | <input type="checkbox"/> Hepatitis B             |
| <input type="checkbox"/> Pertussis Only | <input type="checkbox"/> Pneumococcal Conjugate  |
| <input type="checkbox"/> Polio          | <input type="checkbox"/> Meningococcal Conjugate |
| <input type="checkbox"/> MMR            | <input type="checkbox"/> Varicella               |
| <input type="checkbox"/> Hib            | <input type="checkbox"/> Human Papillomavirus    |
| <input type="checkbox"/> Rotavirus      | <input type="checkbox"/> 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 as long as the medical exemption is warranted.