Division of Public Health
Curtis State Office Building
1000 SW Jackson St., Suite 300
Topeka, KS 66612-1368

Phone: 785-296-1086
www.kdheks.gov

Janet Stanek, Secretary

Laura Kelly, Governor

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
( ) Tdap/Td
( ) Pertussis Only
( ) Polio
( ) MMR
( ) Hib
( ) Rotavirus
( ) Hepatitis A
( ) Hepatitis B
( ) Pneumococcal Conjugate
( ) Meningococcal Conjugate
( ) Varicella
( ) Human Papillomavirus
( ) 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.

Division of Public Health
Curtis State Office Building
1000 SW Jackson St., Suite 300
Topeka, KS 66612-1368

Kansas
Department of Health
and Environment

Phone: 785-296-1086
www.kdheks.gov

Janet Stanek, Secretary

Laura Kelly, Governor

CERTIFICADO DE VACUNACION DE KANSAS– FORMA-B

EXENCIÓN MÉDICA

Nombre del Estudiante:____ Fecha de Nacimiento: ________

Direccion: ____

Ciudad:_______________________________________ Estado:_______ Codigo Postal: ____________

Padre/Tutor: ____

Telefono: _______________________________

Exención médica para las siguientes vacunas:

( ) DTaP
( ) Tdap/Td
( ) (Solo) Tos Ferina
( ) Polio
( ) MMR
( ) Hib
( ) Rotavirus
( ) Hepatitis A
( ) Hepatitis B
( ) Antineumocócica Conjugada
( ) Conjugada contra el Meningococo
( ) Varicela
( ) Virus del papiloma humano
( ) Other: _________________________________

Certifico que la condición física de este niño es tal que la(s) inoculación(es) especificada(s) en este formulario pondrían en grave peligro la vida o la salud de este niño.

Firma:____ Fecha: __________________

**FAVOR DE
IMPRIMIR**

Nombre: ____

Dirreccion: ____

Ciudad:____ Estado:______ Codigo Postal: __________

Telefono: _______________________________

Número de Licencia Médica:______________________________________ Estado de la Licencia: ________

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.