



CATHOLIC SCHOOLS

Diocese of Corpus Christi

MEDICAL EXEMPTION FROM SCHOOL IMMUNIZATION REQUIREMENTS

Student name: _____ Date of Birth: _____
School name: _____ School Year: _____ Grade: _____

Vaccination(s) for which the child should be exempt:

Please check the appropriate box

Contraindication(s) / Serious Health Risk(s):

- ☐ The Patient has the following allergy to the following vaccination(s): _____
and will suffer the following severe allergic reaction: _____.
- ☐ I have diagnosed the Patient with the following immunodeficiency: _____
and if the patient receives the vaccination the patient will face the following serious health risk:
_____.
- ☐ I have diagnosed the Patient with the following neurological disorder: _____
and if the patient receives the vaccination the patient will face the following serious health risk: _____.
- ☐ Valid for school year: _____. **MUST BE RENEWED ANNUALLY.**

Physician Attestation Statement:

I, the undersigned physician, have examined the child named above. Based on my examination and review of his/her medical history, it is my judgment that the vaccination(s) listed above are contraindicated for this child at this time. Receipt of the vaccine(s) would be medically harmful or injurious to the health and wellbeing of the child and/or a household member. It is also my judgment that admitting the child to the school named above, will pose no serious health risk to the rest of the school community, children, or staff.

Physician Signature* (M.D. or D.O.): _____ Date: _____

Date of Exam: _____ Phone #: _____

Physician Name Print: _____ MD/DO License #: _____

* MEDICAL EXEMPTION FROM SCHOOL IMMUNIZATION REQUIREMENTS may only be signed by a physician, M.D. or D.O., licensed to practice in the State of Texas.

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