Division of Public Health
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Kansas
Department of Health and Environment

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Lee A. Norman, M.D., 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 due to: _____

For the following vaccine(s):

( ) DTaP/DT
( ) Tdap/Td
( ) Pertussis Only
( ) Polio
( ) MMR
( ) Hib
( ) Rotavirus
( ) Hepatitis A
( ) Hepatitis B
( ) Pneumococcal Conjugate
( ) Meningococcal Conjugate
( ) Varicella
( ) Human Papillomavirus
( ) Other: _____

PHYSICIAN INFORMATION (PLEASE PRINT)

Name: _____

Street Address: _____

City:_____ State:_____ Zip Code: _____

Telephone: _____

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: _____

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 if the medical exemption is warranted.

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