PHYSICIAN'S MEDICAL EXEMPTION CERTIFICATE

PATIENT'S NAME: _____ DOB _____/_____/_____

INSTRUCTIONS: This form is to be completed by the patient's Pennsylvania-licensed primary healthcare physician or regularly treating pediatric specialist. Medical basis for exemption must be based on guidance from the Centers for Disease Control and Prevention (CDC), Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics (AAP) Red Book. Note:

- Exemption from MMR based on egg allergy will not be accepted. Guidelines are explicit that egg allergy, even if anaphylactic, is not a valid contraindication.
- Autism and/or developmental delay in the child or family member is not a valid reason for exemption for any vaccine and will not be accepted.
- Contact with immunosuppressed persons by a healthy individual is not a valid contraindication for exemption and will not be accepted.
- Pregnancy in the household or contact with a pregnant woman is not a valid contraindication for exemption and will not be accepted.
- Medical exemptions are no more than one year and must be renewed at the start of each school year.

PHYSICIAN: I am the student's primary healthcare physician __ OR regularly treating pediatric specialist __
NAME: (please print) _____
OFFICE ADDRESS_____
DIRECT PHONE LINE _____ ext ___ Date_____

I understand that this Certificate will be reviewed by a panel of pediatric physicians for their recommendation as to whether the medical exemption request should be granted. I further understand that the patient's parent(s) or guardian has executed the attached Parental Application for Medical Exemption, which authorizes release of the patient's medical information relative to the exemption request to the physician panel. I agree to promptly and fully reply to panel requests for medical information pertaining to this Certificate.

I REQUEST: □ Attached Catch-up Vaccine Schedule □ Medical Exemption **:**
for the following required immunization(s) (check all that apply) and certify that the particular immunization(s) will be detrimental to the child's health:

Hepatitis B ___ DTaP/Tdap ___ Polio ___ MMR ___ Varicella ___ MenACWY ___

For children up to the 5th birthday: PCV13 ___ Hib ___

Please describe in detail the patient's contraindication(s)/precaution(s) here (attach additional pages if needed):

_____

_____

_____

Date exemption ends (if applicable): _____

Physicians original signature _____ Degree: _____ Pa. License # _____

FOR INSTITUTION USE ONLY: EXEMPTION: APPROVED ____ DENIED____ Date: _____