Certificate of Exemption—Medical

For School, Child Care, and Preschool Immunization Requirements

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):

NOTICE: This form may be used to exempt a child from the requirement of vaccination when a health care practitioner has determined specific vaccination is not advisable for the child for medical reasons. This form must be completed by a health care practitioner and signed by the parent/guardian. An exempted child/student may be excluded from school or child care during an outbreak of the disease they have not been fully vaccinated against. Vaccine preventable diseases still exist, and can spread quickly in school and child care settings.

Medical Exemption

A health care practitioner may grant a medical exemption to a vaccine required by rule of the Washington State Board of Health only if in their judgment, the vaccine is not advisable for the child. When it is determined that this particular vaccine is no longer contraindicated, the child will be required to have the vaccine (RCW 28A.210.090). Providers can find guidance on medical exemptions by reviewing Advisory Committee on Immunization Practices (ACIP) recommendations via the Centers for Disease Control and Prevention publication, "Guide to Vaccine Contraindications and Precautions," or the manufacturer's package insert. The ACIP guide can be found at: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

*Please indicate which vaccination the **medical** exemption is referring to by disease. If the patient is not exempt from certain vaccinations, mark "not exempt.":*

Disease	Not Exempt	Permanent Exempt	Temporary Exempt	Expiration Date for Temporary Medical
Diphtheria	☐	☐	☐	
Hepatitis B	☐	☐	☐	
Hib	☐	☐	☐	
Measles	☐	☐	☐	
Mumps	☐	☐	☐	
Pertussis	☐	☐	☐	
Pneumococcal	☐	☐	☐	
Polio	☐	☐	☐	
Rubella	☐	☐	☐	
Tetanus	☐	☐	☐	
Varicella	☐	☐	☐	

Health Care Practitioner Declaration

I declare that vaccination for the disease(s) checked above is/are not advisable for this child. I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child. I certify I am a qualified MD, ND, DO, ARNP or PA licensed in Washington State, and the information provided on this form is complete and correct.

X_____   _____   _____

Licensed Health Care Practitioner Name (print)   Licensed Health Care Practitioner Signature   Date

☐ MD ☐ ND ☐ DO ☐ ARNP ☐ PA   Washington License #_____

Parent/Guardian Declaration

I have discussed the benefits and risks of immunizations with the health care practitioner granting this medical exemption. I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

X_____   _____   _____

Parent/Guardian Name (print)   Parent/Guardian Signature   Date