

Immunization Program
Division of Health
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Robert Moser, MD, Acting Secretary

Department of Health & Environment

Sam Brownback, 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):**

- | | |
|---|--|
| <input type="checkbox"/> DTaP/DT | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Tdap/Td | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Pertussis Only | <input type="checkbox"/> Pneumococcal Conjugate |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Meningococcal Conjugate |
| <input type="checkbox"/> MMR | <input type="checkbox"/> Varicella |
| <input type="checkbox"/> Hib | <input type="checkbox"/> Human Papillomavirus |
| <input type="checkbox"/> Rotavirus | <input type="checkbox"/> 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.