Immunization Program
Division of Health
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Topeka, KS 66612

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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):

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

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