



MEDICAL EXEMPTION FROM MEASLES, MUMPS, AND RUBELLA IMMUNIZATIONS

Student's full name \_\_\_\_\_

Student ID # \_\_\_\_\_ Date of Birth \_\_\_\_\_

In the event of an outbreak of measles, mumps or rubella, I understand I may be excluded from school by the local health officer or the State Department of Health and Human Services until I am no longer at risk for contracting or transmitting said disease.

Student Signature and date \_\_\_\_\_

SECTION BELOW FOR MEDICAL PROVIDER

Reason for medical exemption from MMR's: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Permanent Exemption

Temporary Exemption  Expires: \_\_\_\_\_

Health Care Provider
Printed Name and Credentials \_\_\_\_\_

Signature and Credentials \_\_\_\_\_ Date \_\_\_\_\_

Clinic Name, Address and Information or Clinic Stamp