MEDICAL EXEMPTION FORM

New Jersey State Department of Health
Medical Contraindication
School Immunization Record Series

Name of Child (Last, First, M.I.)	Birth Date (Mo/Day/Yr)	Gender

Section A: For completion by **PARENT/GUARDIAN**

By submission of this form, the parent(s) and/or guardian(s) of the above-named child acknowledge that:

1) the child may be excluded from school in accordance with N.J.A.C. 8:57-4.3(d) and (e), based upon the medical exemption from recommended immunization; and
2) when the child's medical condition permits immunization, this exemption shall thereupon terminate and the child shall be required to obtain the immunization(s) from which he or she has been exempted; and
3) this statement will be kept by the school, preschool, or child care center as part of the child's immunization record and shall be reviewed annually by the school, preschool, or child care facility, in accordance with N.J.A.C. 8:57-4.3(c); and
4) Section B of this Form must be fully completed and signed by a physician/advanced practice nurse to effectuate a medical exemption to any required immunization.

Upon completion, this Form will be attached to Standard Immunization Record as to the above-named child.

_____
Parent or guardian signature

Section B: For completion by **PHYSICIAN/ADVANCED PRACTICE NURSE**

By executing this form below, the individual signing below is certifying that:

1) He or she is a the physician licensed to practice medicine or osteopathy in the jurisdiction indicated within the United States; or

2) He or she is an advanced practice nurse (certified registered nurse practitioner or clinical nurse specialist) in the jurisdiction indicated within the United States.

and

3) He or she is certifying that:

a. the particular immunization or immunizations stated below are medically contraindicated for the above-named child based upon valid medical reasons as enumerated by the Advisory Committee on Immunization Practices (ACIP) of the United States Public Health Service or the American Academy of Pediatrics (AAP) guidelines, as indicated below; and

a. the child is exempt from the specific immunization(s) requirement noted below, in accordance with N.J.A.C. 8:57-4.3(b), for period of time stated below:

Exempt from IMMUNIZATION(S)/ANTIGENS for:

_____

_____

Reason for exemption:

_____

_____

_____

This exemption shall continue until:

_____

Physician or Advanced Practice Nurse Stamp:

_____ _____

Physician or Advanced Practice Nurse Signature Date