IOWA | Health and Human Services

Medical Certificate of Immunization Exemption

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

The above named applicant qualifies for a medical exemption to immunization for the following reason (select one):

☐ In the opinion of a physician, nurse practitioner, or physician assistant the following required immunization(s) would be injurious to the health and well-being of the applicant or any member of the applicant's family or household (contraindication due to contact with family or household member applies only to MMR and Varicella vaccine). Select only those vaccines which are medically contraindicated:

- ☐ Hepatitis B (Hep B)
- ☐ *haemophilus influenzae* type b (Hib)
- ☐ Varicella (Chickenpox)
- ☐ Diphtheria, Tetanus, Pertussis (DTaP)
- ☐ Pneumococcal (PCV)
- ☐ Tetanus, Diphtheria, Pertussis (Tdap)
- ☐ Polio (IPV)
- ☐ Measles, Rubella (MMR)
- ☐ Meningococcal (MenACWY)

If, in the opinion of the physician, nurse practitioner, or physician assistant issuing the medical exemption, the exemption should be terminated or reviewed at a future date, an expiration date shall be recorded on the Certificate of Immunization Exemption.

☐ Administration of the following required vaccine(s) would violate minimum interval spacing of at least 28 days from a dose of a previously received live vaccine. In this circumstance, the exemption shall apply only to an applicant who has not received prior doses of exempted vaccine. An expiration date, not to exceed 60 days, shall be recorded on the certificate. Check only the immunizations which are medically contraindicated:

- ☐ Measles, Rubella (MMR)
- ☐ Varicella (Chickenpox)

Certificate Expiration Date: _____

A child granted a medical exemption may be excluded from child care or school during a disease outbreak. The length of time a child is excluded from child care or school will vary depending on the type of disease and the circumstances surrounding the outbreak, and could range from several days to over a month. A Certificate of Immunization Exemption for medical reasons is valid only when signed by an Iowa licensed physician, nurse practitioner, or physician assistant.

The Medical Exemption shall be submitted by the applicant or, if the applicant is a minor, by the applicant's parent or guardian to the admitting official of the school or licensed child care center in which the applicant wishes to enroll.

By signing this certificate, I certify the immunizations specified on this certificate would be injurious to the health of the applicant, to a member of the applicant's family or household, or the required vaccine would violate the minimum interval spacing.

Name (Print): _____ Iowa Medical License Number: _____
Physician (MD or DO), Physician Assistant, or Nurse Practitioner

Signature: _____ Date: _____
Physician (MD or DO), Physician Assistant, or Nurse Practitioner