

## **Preschool-12**<sup>th</sup> **Grade** – **Medical Immunization Exemption Certificate**For Use in Public, Private and Charter Schools

Nevada State Immunization Program • 4150 Technology Way Suite 210 • Carson City, NV 89706 http://dpbh.nv.gov/Programs/Immunizations/ • (775) 684-5900 • nviz@health.nv.gov

## Instructions for completing a Medical Immunization Exemption Certificate

**Section 1:** Enter school and student information.

Section 2: For health care provider use only. Please provide name, address, vaccine contraindication(s), signature and date.:

Section 3: For school use only: Obtain school signatures and dates.

Section 1: School and Student Information						
Name of School (accepting exemption)	Street Address		City	Zip Code	Phone	
Student's Name			Date of Birth	Grade/Level		
Street Address		City	Zip Code	Phone		
Section 2: For Healthcare Provider Use Only - Provide name, address, vaccine contraindication(s), signature, and date.						
Name of Healthcare Provider	rider Street A		City	Zip Code	Phone	
<ol> <li>I certify that due to a contraindication(s), the above named student is exempt from receiving the required vaccine(s)</li> <li>The contraindication(s) marked below is in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines, American Academy of Pediatrics (AAP) guidelines, or vaccine package insert instructions: (Check where applicable)</li> <li>DTaP</li></ol>						
		I WIEHACW I			varicena	
Permanent Contraindications		Temporary Contraindications until (date)				
<ul> <li>☐ Serious allergic reaction (e.g., anaphylaxis) after a previous vaccine dose (General for all vaccines)</li> <li>☐ Serious allergic reaction (e.g., anaphylaxis) to a vaccine component (General for all vaccines)</li> </ul>		<ul> <li>☐ Recent administration of an antibody-containing blood product (MMR, Varicella)</li> <li>☐ Student is pregnant (MMR, Varicella)</li> <li>☐ Thrombocytopenia/thrombocytopenic purpura - now or by history (MMR)</li> <li>☐ Other</li> </ul>				
Previous encephalopathy not attributable to another identifiable cause within 7 days of administration of		Precautions				
previous dose of DTaP/DTP/Tdap  Progressive neurological problem after DTaP/DTP  MMR contraindicated because of immunodeficiency, due to any cause  Varicella contraindicated with substantial suppression of cellular immunity  Other		Any of the conditions below after a previous dose of DTP or DTaP:  Neurologic disorder – unstable or evolving  Fever of >105° F (40.5° C) unexplained by another cause (within 48 hrs)  Seizure or convulsion within 72 hours  Persistent, inconsolable crying lasting > 3 hours (within 48 hours)  Collapse or shock like state (within 48 hours)  Guillain-Barré Syndrome (within 6 weeks)  Other precautions for required vaccines:				
Precaution for DTaP, DT, Td, Tdap						
☐ History of arthus-type hypersensitivity, defer Tetanus-toxoid vaccine for at least 10 years						
Parent/student has been informed that if an outbreak of vac school administrative head for a period of time as determin public health risk.						
MD, DO, or APRN Signature Only a Nevada-licensed DO, MD or APRN may sign form unless representing a tribal clinic or design			License N	Jumber	Date	
Section 3: For School Official Use Only: Please						
School Nurse or Designee Signature			Date			
School Board or Designee Signature			Date			
It is the responsibility of the administrative head of the exclude students who have not received the minimum n	school to					