KANSAS CERTIFICATE OF IMMUNIZATIONS - FORM B
MEDICAL EXEMPTION

Student Name:__________________________________________  Birthdate: __________

Street Address: ________________________________________

City: __________________________________________________ State:_______ Zip Code: __________

Parent/Guardian: _______________________________________

Telephone: ____________________________________________

Medical exemption for the following vaccine(s):
( ) DTaP  ( ) Hepatitis A
( ) Tdap/Td ( ) Hepatitis B
( ) Pertussis Only ( ) Pneumococcal Conjugate
( ) Polio ( ) Meningococcal Conjugate
( ) MMR ( ) Varicella
( ) Hib ( ) Human Papillomavirus
( ) Rotavirus ( ) 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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