

Preschool-12th **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 5: For school use only. Obtain school signature	ies and da	ites.			
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 - I	Provide 1	name, address, vaccine o	contraindication(s), signature, an	d date.
Name of Healthcare Provider Street		Address	City	Zip Code	Phone
I certify that due to a contraindication(s), the above The contraindication(s) marked below is in accorda American Academy of Pediatrics (AAP) guidelines	nce with	the Advisory Committee o	n Immunization Pr	actices (ACIP) gu	uidelines,
□ DTaP □ Hepatitis A □ Hepatitis B	□IP	V		☐ Td/Tdap	☐ Varicella
Permanent Contraindications	Temporary Contraindications until (date)				
 ☐ Serious allergic reaction (e.g., anaphylaxis) after a previous vaccine dose (General for all vaccines) ☐ Serious allergic reaction (e.g., anaphylaxis) to a vaccine component (General for all vaccines) 		 □ Recent administration of an antibody-containing blood product (MMR, Varicella) □ Student is pregnant (MMR, Varicella) □ Thrombocytopenia/thrombocytopenic purpura - now or by history (MMR) □ Other 			
☐ 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 Teta	nus-toxo	id vaccine for at least 10 y	ears		
Parent/student has been informed that if an outbreak of va school administrative head for a period of time as determi 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 1	Number	Date
Section 3: For School Official Use Only: Pleas			·		
School Nurse or Designee Signa		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	school to	secure compliance with the frequired immunizations as	e regulations. The and who are not exer	administrative hea	d of the school shall e regulations.