



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
**MEDICAL IMMUNIZATION EXEMPTION**

**FOR LICENSED DOCTOR OF  
 MEDICINE OR DOCTOR OF  
 OSTEOPATHY ONLY**

REQUIRED UNDER THE STATE IMMUNIZATION LAWS (SECTION 167.181 AND SECTION 210.003, RSMo) FOR SCHOOL AND PUBLIC, PRIVATE OR PAROCHIAL PRESCHOOL, DAY CARE CENTER, PRESCHOOL, OR NURSERY SCHOOL CARING FOR TEN OR MORE CHILDREN

Unimmunized children have a greater risk of contracting and spreading vaccine-preventable diseases to babies who are too young to be fully immunized and those who cannot be immunized due to medical conditions. In the event of an outbreak or suspected outbreak of a vaccine-preventable disease within a particular facility, children who are not fully immunized or do not have documented laboratory evidence of immunity shall not be allowed to attend school or day care until the local health authority declares the designated outbreak or health emergency has ended.

<b>THIS IS TO CERTIFY THAT</b>	NAME OF CHILD (PRINT OR TYPE)
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IS EXEMPT FROM RECEIVING THE FOLLOWING IMMUNIZATION(S) BECAUSE:

- The child has documentation of disease or laboratory evidence of immunity to the disease. \_\_\_\_\_ (MONTH/YEAR)
  - The physical condition of the above-named child is such that immunization would endanger their life or health or is medically contraindicated due to other medical conditions.
- |                                     |                                       |                                |                                  |
|-------------------------------------|---------------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> DIPHTHERIA | <input type="checkbox"/> HEPATITIS B  | <input type="checkbox"/> HIB   | <input type="checkbox"/> MMR     |
| <input type="checkbox"/> PERTUSSIS  | <input type="checkbox"/> PNEUMOCOCCAL | <input type="checkbox"/> POLIO | <input type="checkbox"/> TETANUS |
| <input type="checkbox"/> VARICELLA  | <input type="checkbox"/> OTHER _____  |                                |                                  |

PHYSICIAN/PHYSICIAN'S DESIGNEE NAME (PRINT OR TYPE)

PHYSICIAN SIGNATURE

DATE