

MEDICAL EXEMPTION FROM VACCINATION REQUIRED FOR SCHOOL ATTENDANCE IN NEBRASKA

As the Physician, Physician Assistant or Advanced Practice Registered Nurse – Nurse Practitioner of:

<i>Child's Last Name</i>	<i>First Name</i>	<i>Age</i>
/ /		
<i>Birth Date (mm/dd/yyyy)</i>	<i>School</i>	<i>Grade</i>

I have elected to not immunize this student against the following disease(s):

Each disease for which a vaccine has not been administered must be checked. Parent/guardian must submit dates of immunizations for all other diseases.

- Diphtheria/Tetanus/and or Pertussis (DTaP, Tdap)
- Polio (IPV)
- Haemophilus Influenzae Type B (Hib)
- Hepatitis B
- Measles/Mumps/and or Rubella (MMR)
- Varicella
- Pneumococcal (PCV13)

In my opinion, this immunization would be injurious to the health and well-being of:

- The student
- A member of the student's household or family

Comments: _____

<i>Signature of Physician, Physician Assistant, or Advanced Practice Registered Nurse – Nurse Practitioner</i>	<i>Date</i>
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