Public Health Division

Oregon Immunization Program

OREGON HEALTH AUTHORITY

Oregon Medical Exemption Form

See page 2 for instructions.

Section A - Must be completed by a physician* **

Child's Name: _____ Child's Date of Birth: _____

School or Child Care Name: _____

Medical condition that is a contraindication or precaution to vaccination per the Centers for Disease Control and Prevention or the American Academy of Pediatrics (OAR 333-050-0270):

_____

_____

_____

Vaccines contraindicated or with a precaution (check all that apply):

- ☐ Diphtheria/Tetanus/Pertussis
- ☐ Polio
- ☐ Varicella
- ☐ Measles/Mumps/Rubella
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hib

The medical condition is expected to be (check one):

- ☐ Permanent
- ☐ Temporary - Date expected to resolve: _____

Physician or Local Health Department Representative Signature: _____

Physician or Local Health Department Representative Name: _____

Physician License Number and State: _____ Date: _____

Clinic Name: _____

Clinic Address: _____

Clinic Phone Number: _____

*"Physician" means a physician licensed by the Oregon Medical Board or by the Oregon Board of Naturopathic Medicine or a physician similarly licensed by another state or country in which the physician practices or a commissioned medical officer of the Armed Forces or Public Health Service of the United States. ORS 433.235.
**A representative of the local health department (LHD) may complete Section A instead of a physician.

Child's Name:_____ Child's Date of Birth:_____

Directions for Physicians:

1. Fill out Section A.
2. Return this form to the child's parent/guardian and keep a copy for your records.

Directions for Parents/Guardians:

1. Bring the completed form to your child's school or child care, and keep a copy for your records.

Directions for Schools/Child Care Facilities:

1. If Section A of the Medical Exemption Form was completed by a physician, submit the form to the local health department for review.
2. Keep a copy of this form with the local health department's review in the child's record.

Directions for Local Health Departments:

1. Review Section A of the form for completeness and whether the condition is a contraindication or precaution to immunization.
2. Fill out Section B.
3. Return the form to the school/child care and keep a copy for your records.

Section B - For Local Health Department Use Only

This request for a medical exemption is:

☐ Approved

- ◯ Permanent
- ◯ Temporary Review date:_____

☐ Denied Reason:_____

_____

_____

Local Health Department Representative Signature:_____

Local Health Department Representative Name:_____ Date:_____

Local Health Department Representative Title:_____

Local Health Department Phone Number:_____

Local Health Department Email Address:_____