THE SCHOOL DISTRICT OF PHILADELPHIA

Immunization Exemption Form

(Medical/Religious/Philosophical)

For School Immunization Requirements

Student's Full Name:	Birthdate (mm/dd/yyyy):	Grade Level:	Student ID:
Parent or Guardian's Name:		Telephone Number:	
Street Address:	City:	State:	Zip Code:

NOTICE: When a health care practitioner has determined a specific vaccination is not advisable for the child for medical reasons, this form must be completed by a physician and submitted to the student's school at the start of each school year.

Medical Exemption

Children need not be immunized if a physician or the physician's designee provides a written statement that immunization may be detrimental to the health of the child. (Please indicate which vaccine antigen(s) the medical exemption is referring to):

☐ Medical

☐ Diphtheria	☐ Tetanus	☐ Acellular Pertussis	☐ Polio
☐ Hepatitis B	☐ Measles	☐ Mumps	☐ Rubella
☐ Varicella (chickenpox)	☐ Meningococcal	☐ COVID-19	

Physician Declaration

I declare that the physical condition of the above-named child is such that immunization would endanger life or health.

Physician Name (print)	Physician Signature	Date

NOTICE: A parent or guardian may exempt their student from the vaccinations listed below by submitting this completed form to the student's school at the start of each school year.

Personal/Philosophical or Religious Exemption

I am exempting my child from the requirement that my child be vaccinated against the following disease(s) to attend school.
(Select an exemption type and the vaccinations you wish to exempt your child from):

☐ Personal/Philosophical ☐ Religious

☐ Diphtheria	☐ Tetanus	☐ Acellular Pertussis	☐ Polio
☐ Hepatitis B	☐ Measles	☐ Mumps	☐ Rubella
☐ Varicella (chickenpox)	☐ Meningococcal	☐ COVID-19	

State your reason for requesting this exemption:

Parent/Guardian Declaration

One or more of the required vaccines are in conflict with my personal, philosophical, or religious beliefs. I understand that if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school for the duration of the outbreak. I affirm that the information on this form is complete and correct.

Parent/Guardian Name (print)	Parent/Guardian Signature	Date

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Medical Plan

(Medical Certificate)

For School Immunization Requirements

NOTICE: This form must be used when a health care practitioner has determined that an alternative immunization schedule is necessary. This form must be completed and signed by a health care practitioner and submitted to the student's school.

VACCINE Circle appropriate item	Enter month, day and year each immunization **will be given** DOSES				
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	or measles serology Date	Titer	
Varicella	1 / /	2 / /	Rubella serology Date	Titer	
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		

Attach EHR of vaccines already given.

Physician Name (print) Physician Signature Date

Signature (PLEASE CIRCLE - physician, certified registered nurse practitioner, physician assistant, local health department)