FORT WORTH INDEPENDENT SCHOOL DISTRICT
Health Services Department

Medical Exemption

Date _____

School Name _____ *School #* _____

Name of Student _____ *DOB* _____

In my opinion, the required immunization(s) listed below would be injurious to the health and well being of the applicant or any member of his/her family or household due to the following reasons:

_____
_____
_____

Specific vaccination(s) contraindicated:

_____
_____
_____
_____

Name of Physician _____ *Physician* _____
(Please print or stamp)

Address _____ *Phone #* _____

A physician licensed to practice medicine in the United States must complete this form. (cannot use homeopathic practitioner or chiropractors)

_____

Unless a lifelong condition is specified, the affidavit or certificate is valid only one year from the date signed by the physician and must be renewed every year for the exclusion to remain in effect.