Appendix B

MEDICAL EXEMPTION FROM VACCINATION REQUIRED FOR SCHOOL ATTENDANCE IN NEBRASKA

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

_____	_____	_____
Child's Last Name	*First Name*	*Age*
_____/_____/_____	_____	_____
Birth Date (mm/dd/yyyy)	*School*	*Grade*

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.

- ☐ Diptheria/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:_____
_____

_____	_____
Signature of Physician, Physician Assistant, or Advanced Practice Registered Nurse – Nurse Practitioner	*Date*

Updated 3/6/2019