Heber-Overgaard Schools
"Home of the Mustangs"
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Heber-Overgaard Unified School District

Employee Immunization Medical Exemption Form

Employee Name: _____ **Position/Department:** _____
Date of Birth: _____ **Date:** _____

Purpose:
This form is used for employees who are unable to receive one or more required immunizations due to a medical condition or contraindication as verified by a licensed healthcare provider.

Section A: To Be Completed by Employee

I am requesting a medical exemption from one or more required immunizations based on a medical condition or contraindication. I understand that this request will be reviewed and must be supported by medical documentation.

Immunization(s) for which exemption is requested:
☐ MMR ☐ Tdap ☐ Varicella ☐ Hepatitis B ☐ Other: _____

Employee Signature: _____ **Date:** _____

Section B: To Be Completed by Licensed Healthcare Provider

I certify that the above-named employee has a medical contraindication or precaution that prevents them from safely receiving the following immunization(s):

This contraindication is:
☐ Temporary – may receive vaccine after: _____ ☐ Permanent

Provider Name: _____ **Medical License #:** _____
Phone: _____ **Address:** _____

Provider Signature: _____ **Date:** _____

District Use Only

Reviewed by: _____ Date: _____
☐ Approved ☐ Denied ☐ Additional documentation required

HR/Health Services Representative: _____