Appendix 3

CATHOLIC SCHOOLS DIOCESE OF DALLAS
Medical Exemption for Specific Immunizations

This statement is to be copied or typed on the Medical Doctor's/Doctor of Osteopathy's letterhead, signed by the same individual and include the individual's Texas Medical License number. If hand written, it must be legible to school officials.

Date: _____

Name of Patient: _____

Age of Patient: _____

Name of School: _____

Address of School: _____
_____

On _____ I, the undersigned medical doctor/doctor of osteopathy, examined the Patient named above.

Based on my examination, the Patient will face the following *serious* health risk(s) if the Patient receives the following vaccination(s).
Identify Vaccination(s): _____
_____

Identify Serious Health Risk(s):
The Patient has the following allergy to the vaccination(s) listed above: _____
_____and will suffer the following severe allergic reaction if the Patient receives the vaccination: _____
_____
_____

I have diagnosed the patient with the following immunodeficiency: _____
_____ and if the patient receives the vaccination the patient will face the following serious health risk: _____
_____
_____

I have diagnosed patient with the following neurological disorder: _____
_____ and if the patient receives the vaccination the patient will face the following serious health risk: _____
_____

_____ Printed Name: _____
(Signature of Medical Doctor/Doctor of Osteopathy)
Texas State Medical License #: _____

This signed completed form must be kept on file in the student's permanent folder at the school and a copy sent to the Catholic Schools Office of the Diocese of Dallas.