

Documentation of Tdap Administration or Medical Exemption

Optional Form for Health Care Providers

A) Administration of Tdap

STUDENT NAME (Last, First, Middle) _____

DATE OF Tdap

____ / ____ / 20____
MM DD YYYY

NAME OF CHILD'S PHYSICIAN OR AGENCY WHERE Tdap ADMINISTERED

DATE OF BIRTH

____ / ____ / ____
MM DD YYYY

signature not required

B) Medical Exemption to Tdap

Contraindications to Tdap

It is very rare for children to be given a medical exemption for school immunization requirements by their physicians. Most medical practices have no children with medical conditions that would preclude immunization with Tdap. The only contraindications to immunization with Tdap, both rare, are:

- a documented history of anaphylaxis after receipt of Tdap, DTaP or their ingredients; or
- encephalopathy occurring within 7 days after immunization against pertussis that was not due to another identifiable cause

Exemption Due to Medical Condition

I certify that the child has a permanent medical condition, described below, which prevents immunization against pertussis. I understand that, for the protection of the child and other students, the child may be excluded from attending school for prolonged periods during each outbreak of pertussis or after each exposure to someone with pertussis. (17 CCR §6060)

- History of anaphylaxis after immunization with DTaP
- History of encephalopathy after immunization against pertussis not due to other identifiable cause
- Other (description needed): _____

Signature of physician: _____

Date: _____

Other provider documentation of a history of Tdap administration (e.g., 'yellow card', registry or medical records) will be accepted.