Ontario

Ministry of Health
and Long-Term Care

Statement of Medical Exemption
Immunization of School Pupils Act

Section 1 – Pupil Information

Last Name	First Name	DOB (yyyy/mm/dd)

Home Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

School Name	Class or Grade

Section 2 – Declaration of Physician or Registered Nurse in the Extended Class (Nurse Practitioner)

I, _____ ,
(Name of physician or registered nurse in the extended class)

certify that, for medical reasons indicated below, the above named pupil should be exempted from the requirements of the Act.
The specific reasons and length of exemptions are checked in the boxes below.
The time periods for temporary medical exemptions are indicated.

Disease	Immunity		Contraindication	Length of Exemption			
	Clinical diagnosis of prior disease	Laboratory confirmation of immunity or prior disease	Detrimental to health	Permanent	Temporary	From yyyy/mm/dd	To yyyy/mm/dd
Diphtheria			☐	☐	☐		/
Tetanus			☐	☐	☐		/
Pertussis			☐	☐	☐		/
Poliomyelitis			☐	☐	☐		/
Meningococcal Disease			☐	☐	☐		/
Measles		☐	☐	☐	☐		/
Mumps		☐	☐	☐	☐		/
Rubella		☐	☐	☐	☐		/
Varicella	☐ *	☐	☐	☐	☐		/

* Clinical diagnosis of prior varicella or herpes zoster disease is acceptable for varicella immunity.

Use this space to define evidence of immunity.

Use this space for explanations of contraindications detrimental to health.

Section 3 – Signature

Name of Physician or Registered Nurse in the Extended Class

Business Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Signature of Physician or Registered Nurse in the Extended Class	Date (yyyy/mm/dd)

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