R.R.O. 1990, Reg. 645, s. 5; O. Reg. 299/96, s. 2; O. Reg. 443/03, s. 1.

FORM 1
STATEMENT OF MEDICAL EXEMPTION

Immunization of School Pupils Act

PUPIL'S NAME: ..... Last Name First Name

ADDRESS: .....

DATE OF BIRTH: ..... / ..... / ..... Year Month Day

SCHOOL: ..... Class or Grade: .....

I, ..., 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	
	Physician diagnosed prior disease	Test evidence of immunity	Detrimental to Health	Permanent	Temporary From To
Diphtheria		☐	☐	☐	☐...../.....
Tetanus		☐	☐	☐	☐...../.....
Poliomyelitis		☐	☐	☐	☐...../.....
Measles	☐	☐	☐	☐	☐...../.....
Mumps	☐	☐	☐	☐	☐...../.....
Rubella		☐	☐	☐	☐...../.....

Use this space to define evidence of immunity: .....

.....

.....

Use this space for explanations of contraindications detrimental to health: .....

.....

.....

.....

Physician's Signature .....

Address: .....

Date: .....

R.R.O. 1990, Reg. 645, Form 1.