

CHILD'S NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
Full Name of Child (PRINT) MM DD YYYY



# IDAHO SCHOOL IMMUNIZATION REQUIREMENTS EXEMPTION

In the event of a disease outbreak, a child exempted from Idaho school immunization requirements may be excluded from school for the duration of the outbreak. Please check the box(es) below for each vaccine-preventable diseases for which an exemption is claimed.

- |  |   |
|--|---|
| <input type="checkbox"/> Diphtheria (DTaP, Tdap, Td)             | <input type="checkbox"/> Hepatitis B  |
| <input type="checkbox"/> Tetanus (DTaP, Tdap, Td)                | <input type="checkbox"/> Hepatitis A  |
| <input type="checkbox"/> Pertussis (Whooping Cough) (DTaP, Tdap) | <input type="checkbox"/> Meningococcal  |
| <input type="checkbox"/> Measles (MMR)                           | <input type="checkbox"/> Varicella (Chickenpox)   |
| <input type="checkbox"/> Mumps (MMR)                             | <input type="checkbox"/> <b>Varicella Disease History:</b> My child has had                     |
| <input type="checkbox"/> Rubella (German Measles) (MMR)          | <input type="checkbox"/> chickenpox but was not diagnosed by a licensed healthcare professional |
| <input type="checkbox"/> Polio (IPV)                             | <input type="checkbox"/> All required immunizations   |

I decline to provide details regarding my child's immunization status.  
*NOTE: Your child will be considered exempt from all required school immunizations.*

- MEDICAL EXEMPTION (Requires the signature of a licensed physician)**  
As this child's physician, I certify that the physical condition of this child is such that the immunization(s) checked above would endanger the health of the child.
- This medical exemption is permanent.
- This medical exemption is temporary. Duration of temporary exemption: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

I hereby request that this child be exempted from the Immunization Requirements for Idaho School Children ([IDAPA 16.02.15](#)) due to a medical condition for which immunizations are contraindicated.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name of Licensed Healthcare Provider (PRINT) Signature of Licensed Healthcare Provider Date (MM/DD/YYYY)

- RELIGIOUS/OTHER EXEMPTION** As the child's parent/guardian, I am exempting for religious or other reasons.

As the child's parent/guardian, I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak. By signing this form, I am not waiving any of my child's rights to an education under [Article 9, Section 1 of the Idaho Constitution](#) if my child is excluded from school during a disease outbreak.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name of Parent/Guardian (PRINT) Signature of Parent/Guardian Date (MM/DD/YYYY)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Full Name of Exempted Child (PRINT) Child's Date of Birth (MM/DD/YYYY)

Parents/guardians may include a signed written statement regarding religious/other exemptions on the back of this document

