Faribault Public Schools
Health Services
Immunization Request

Date: ________________

Greetings,

According to our health records, ____
is not up to date or doesn't have a complete immunization record.

Per the Minnesota School Immunization Law and Faribault Public Schools Immunization Policy #530: Without this information we cannot allow the student to attend school longer than thirty days unless we have received proof that they have had the required immunizations or are exempted therefrom.

In order for your child to attend school in accordance with MN State Law, their record _must**_ be current.** Please make appropriate arrangements to obtain your child's record or have their shots updated immediately.

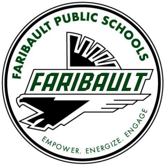
The following immunizations are needed, according to our records:

_____ DTaP / Tdap (Diphtheria, Tetanus, Pertussis)
_____ Hib (Haemophilus influenzae type b)
_____ HAV (Hepatitis A)
_____ HBV (Hepatitis B)
_____ IPV (Polio)
_____ MCV4- ACWY (Meningococcal)
_____ MMR (Measles, Mumps and Rubella)
_____ PCV (Pneumococcal)
_____ Varicella (Chicken Pox)
_____ A Complete Immunization Record is needed

Sincerely,

Faribault Public Schools Health Services

Enclosure: Exemption Form (on back)
cc: Building Administrator



Faribault Public Schools
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CHILD'S NAME (FIRST, LAST):________________________________ **CHILD'S DATE OF BIRTH:**____________________

Medical and non-medical exemptions

Instructions for documenting medical or non-medical exemptions and history of chickenpox (varicella)

Follow steps 1 and 2 below to document a medical exemption, non-medical exemption, or history of chickenpox.

1. Place an X in the box to indicate a medical or non-medical exemption. If you are exempting your child from more than one vaccine, mark each vaccine you are exempting them from with an X.
2. Obtain signatures for exemptions or history of chickenpox disease.

Required Immunizations	Medical	Non-Medical
Hepatitis B (Hep B)		
Polio (IPV)		
Measles, mumps, rubella (MMR)		
Varicella (Chickenpox)		
Diphtheria, tetanus, and pertussis (DTaP)		
Tetanus, diphtheria, and pertussis (Tdap)		
Meningococcal ACWY (MenACWY)		

Medical exemption: A health care provider must review and sign a medical exemption. A health care provider includes a licensed physician, nurse practitioner, or physician assistant.

By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: ____________________________
(of health care practitioner)

Date: __________________

Non-medical exemption: A parent/guardian must sign for a non-medical exemption and the form must be signed and stamped by a notary. A child is not required to have an immunization that is against their parent or guardian's beliefs. Choosing not to vaccinate may put the health of your child or others they are around at risk. Unvaccinated children who are exposed to a vaccine preventable disease may be required to stay home from school and other activities for up to 21 days to protect themselves and others.

By my signature I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs and I understand that they may be required to remain out of school and other activities for up to 21 days if exposed to a vaccine preventable disease.

Signature:____Date:______________
(of parent/guardian)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me on

________________________________ (date),

by ____
(name of parent or guardian)

Notary Signature:

____

Notary Stamp

State of ____________________________________,
County of ____________________________________

History of chickenpox (varicella) disease: If a child has previously had chickenpox, they are not required to receive the varicella vaccine. A health care provider must sign this form if the disease happened after Sept. 1, 2010. If the child had chickenpox before Sept. 1, 2010, a parent or guardian may sign this form.

My signature below means that I confirm this child does not need the varicella vaccine because they had chickenpox in the month and year ___________________________
Signature:_____________________________________ Date:_______________________
(of health care practitioner, representative of a public clinic, or parent/ guardian)