Immunization Exemption

- Section I to be completed by Parent/ Guardian
- Section II to be completed by a health care provider if there is a medical exemption.
- Return to the school nurse upon completion.

Section I. Parent/ Guardian Section

Name of Child: _____ Date of Birth: _____
Address: _____
School: _____

As required under the Compulsory Immunization Law (Ohio Revised Code, Section 3313.67 and 3313.671), I hereby signify by my signature that I object for the reason stated below to the immunization of my child against the following disease(s):

___Polio ___Diphtheria/Tetanus/Pertussis (DTaP) ___Measles ___Mumps ___Rubella
___Hepatitis B ___Tdap ___Varicella (Chickenpox) ___ Meningococcal

Reason for Exemption (check one)
_____ Religious reasons _____ Philosophical reasons _____Medical reasons

I am aware that my child is subject to exclusion from school as required by the Ohio Department of Health in the event of any outbreak of the communicable disease(s) that I have checked above, and that this exclusion may last for the duration of the outbreak, which could extend over a period of several weeks.

Parent/Guardian Signature: _____Date: _____

Section II. Health Care Provider

Please check contraindicated immunizations for medical exemption.
___Polio ___Diphtheria/Tetanus/Pertussis (DTaP) ___Measles ___Mumps ___Rubella
___Hepatitis B ___Tdap ___Varicella (Chickenpox) ___ Meningococcal

Reason for medical exemption:_____

Time frame for medical exemption: _____

Provider Signature/Title:
_____Date:_____
(ONLY required when this is a medical exemption)