



Dublin City School District
Immunization Exemption

Students
5320 F2
Revised 9/14/26

- Section I to be completed by the 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.

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 (DTP) ☐ Measles ☐ Mumps ☐ Rubella
☐ Hib ☐ Hepatitis-B ☐ Tdap ☐ Varicella (Chickenpox) ☐ Meningococcal

Reason for exemption: _____

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:** _____

By typing your name above, you agree that your typed signature is the legal equivalent of your manual signature on this form. You may also print, hand-sign, and return this form if you prefer.

II. Health care provider section

Please check contraindicated immunizations for medical exemption.

☐ Polio ☐ Diphtheria/Tetanus/Pertussis (DTP) ☐ Measles ☐ Mumps ☐ Rubella
☐ Hib ☐ 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)