REFUSAL OF IMMUNIZATION
For Medical Reasons

As the physician of:

_____
Child's Last Name First Name Age

_____
Birth Date School Grade

A. I have elected to not immunize this student against the following disease(s): (check box*)

☐ Diphtheria

☐ Tetanus

☐ Pertussis

☐ Polio

☐ Measles (Rubeola)

☐ Mumps

☐ Rubella (German Measles)

☐ Hepatitis B

☐ Varicella (chickenpox)

In my opinion, this/these immunization(s) would be injurious to the health and well-being of

☐ The student

☐ A member of the student's household or family

Comments _____

_____

_____
Signature of Physician Date

* Each disease for which a vaccine has not been administered must be checked. Parent / guardian must submit dates of immunization for all other diseases.

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