REQUEST FOR EXEMPTION TO IMMUNIZATION

(OR LABORATORY PROOF OF IMMUNITY)

If you wish your child to be exempt from the immunization requirements, this form must be completed, signed and returned to school or day care center. By state law, (A.R.S. § 15-873) your child will not be allowed to attend school or day care until either a record of immunization or this exemption statement is submitted. Please indicate below the type of exemption requested and complete all required information. *In the event of an outbreak of a vaccine preventable disease for which you cannot provide proof of immunity of your child, your child will not be allowed to attend school or day care until the risk period ends.*

MEDICAL REASONS

If immunization would be a health risk to the child because of pre-existing medical conditions, you must sign the statement below *along with your physician's signature.* Your physician must state below the reason for the medical exemption. The exemption may be for one or more vaccines, and may be either permanent or temporary. If the condition is temporary, the date of its end must be given, at which time the child must receive any necessary vaccine doses.

PERSONAL BELIEFS

If immunizations are against your personal or religious beliefs, you must sign the statement below to exempt your child from the requirements.

LABORATORY EVIDENCE

If your child has previously had a vaccine preventable disease, immunization against that disease is not required if laboratory evidence of immunity signed by a physician can be provided. *Copies of lab results must accompany this request.*

COMPLETE AND RETURN THIS FORM TO YOUR CHILD'S SCHOOL OR DAY CARE CENTER:

I hereby request an exemption from the immunization requirements for the child listed below, have received information about immunization and understand the risks and possible outcomes of this decision.

Child's Name_____ Date of Birth_____

Type of Exemption Requested:
(Mark One)
____Medical* (see below)
____Personal Beliefs
____Laboratory Evidence

For the Following Vaccines:
(Mark All That Apply)
____Diphtheria ____Tetanus ____Pertussis
____Measles ____Mumps ____Rubella
____Polio ____Haemophilus Influenzae B

* If a medical exemption is marked, complete the following:

Reason for Medical Exemption:
_____
_____

Length of Exemption:
____Permanent
____Temporary Until:_____(mo/da/yr)

Required Signatures: Parent or guardian must sign all requests, and physician must also sign any requests for medical or laboratory evidence exemptions.

_____
Parent or Guardian

_____
Printed Name

_____
Date

_____
Physician or Health Agency Representative

_____
Printed Name

_____
Date

ADHS Form 209 (4/91)