

AFFIDAVIT OF IMMUNIZATION EXEMPTION For Household Members Age 13 and Younger

GENERAL INFORMATION

Child's Name (*Last, First*) _____ Date of Birth (*MM/DD/YYYY*) _____

MEDICAL EXEMPTION REASON(S)

I hereby request an exemption from the immunization requirements for the child named above due to the medical condition that causes the required immunizations to endanger the child's health.

Length of exemption: Permanent Temporary until: _____

Health Care Provider's Name (*Last, First*) _____ License or Certificate No. _____ Issuing State and/or Country* _____

Health Care Provider's Address (*No., Street*) _____

City _____ State _____ ZIP Code _____ Phone Number _____

Type of Health Care Provider

Physician Physician's Assistant Registered Nurse Registered Nurse Practitioner

Health Care Provider's Signature _____ Date _____

*The license or certificate issued by another state or country may not be accepted if it cannot be verified.

RELIGIOUS BELIEFS

I hereby request an exemption from the immunization requirements for the child named above due to my religious teachings.

Provider's Name (*Print*) _____ Provider's Signature _____ Date _____

EXEMPTION IS GIVEN FOR THE FOLLOWING: (*check 'x' all that apply*)

Yes	No	Diphtheria	Yes	No	Haemophilus Influenzae Type b	Yes	No	Measles
Yes	No	Mumps	Yes	No	Pertusis	Yes	No	Poliomyelitis
Yes	No	Rubella	Yes	No	Tetanus	Yes	No	Hepatitis A
Yes	No	Meningococcal	Yes	No	Hepatitis B	Yes	No	Varicella
Yes	No	Other _____						

IN-HOME PROVIDERS ONLY

In accordance with R6-5-5202(L) and R6-5-52025(M), I hereby request a waiver from the immunization and TB requirements for the child named above. I will be certified as an in-home provider, and **I attest my household members will not be present when child care services are provided.**

Provider's Name (*Print*) _____ Provider's Signature _____ Date _____

Initials I understand that in the event of an outbreak of a vaccine preventable disease for which I cannot provide proof of immunity for the child, the child will be excluded from the DES certified home until the risk period ends.

Initials I will notify all parents/guardians that one or more of my child-household members are granted immunization exemption before child care services are provided.

Provider's Name (*Print*) _____ Provider's Signature _____ Date _____