CCA-1164A FORFF (5-23)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Child Care

AFFIDAVIT OF IMMUNIZATION EXEMPTION FOR CHILDREN IN CARE

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* _____

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.

Parent or Guardian's Name *(Print)* _____

Parent or Guardian'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

Other ☐ Yes ☐ No _____

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.

Parent or Guardian's Name *(Print)* _____

Parent or Guardian's Signature _____ Date _____