Request for Exemption to Immunization
Schools

If you wish for your child to be exempt from the immunization requirements, this form must be completed, signed and returned to the school. By state law, (A.R.S.' 15-873) your child will not be allowed to attend school 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 can not provide proof of immunity of your child, your child will not be allowed to attend school until the risk period ends.**

Medical Reasons - If the 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 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 beliefs, you must sign 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:

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____________
(month, day, year)

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 ___ Hepatitis B ___ Varicella
___ Meningococcal

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

Reason for medical exemption:____

____

Length of exemption: Permanent: ________________ Temporary until: ____________________

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	Physician
______________________	______________________
Printed Name	Printed Name
______________________	______________________
Date: month, day, year	Date: month, day, year