

Child's Name: _____

IDAHO SCHOOL IMMUNIZATION REQUIREMENTS EXEMPTION

In the event of a disease outbreak, a child exempted from Idaho school immunization requirements may be excluded from school for the duration of the outbreak. Please check the box(es) below, and date each line regarding all vaccine-preventable diseases for which an exemption is claimed.

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|--|-------|--|-------|
| <input type="checkbox"/> Diphtheria (DTaP, Tdap, Td) | _____ | <input type="checkbox"/> Hepatitis B | _____ |
| | Date | | Date |
| <input type="checkbox"/> Tetanus (DTaP, Tdap, Td) | _____ | <input type="checkbox"/> Hepatitis A | _____ |
| | Date | | Date |
| <input type="checkbox"/> Pertussis (Whooping Cough) (DTaP, Tdap) | _____ | <input type="checkbox"/> Meningococcal | _____ |
| | Date | | Date |
| <input type="checkbox"/> Measles (MMR) | _____ | <input type="checkbox"/> Varicella (Chickenpox) | _____ |
| | Date | | Date |
| <input type="checkbox"/> Mumps (MMR) | _____ | <input type="checkbox"/> Varicella Disease History: My child has had chickenpox but was not diagnosed by a licensed healthcare professional. | _____ |
| | Date | | Date |
| <input type="checkbox"/> Rubella (German Measles) (MMR) | _____ | <input type="checkbox"/> All required immunizations | _____ |
| | Date | | Date |
| <input type="checkbox"/> Polio | _____ | | _____ |
| | Date | | Date |

I decline to provide details regarding my child's exemption status. **NOTE:** Your child will be considered exempt from all required school immunizations.

MEDICAL EXEMPTION (This exemption requires the signature of a licensed physician.)

As the child's physician, I certify that the physical condition of this child is such that the immunization(s) checked above would endanger the health of the child.

- This medical exemption is permanent.
- This medical exemption is temporary. Duration of temporary exemption: ____/____/____

I hereby request that this child be exempted from the Immunization Requirements for Idaho School Children (IDAPA 16.02.15) due to a medical condition for which immunizations are contraindicated.

_____ Name of Physician (PRINT)	_____ Signature of Physician	_____ Medical License #	_____ Date
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As the child's parent/guardian, I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak. By signing this form, I am not waiving any of my child's rights to an education under Article 9, Section 1 of the Idaho Constitution if my child is excluded from school during a disease outbreak.

_____ Name of Parent/Guardian (PRINT)	_____ Signature of Parent/Guardian	_____ Date
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_____ Full Name of Exempted Child (PRINT)	_____ Child's Date of Birth (Month, Day, Year)
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RELIGIOUS/OTHER EXEMPTION

As the child's parent/guardian, I am exempting for religious or other reasons. I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak. By signing this form, I am not waiving any of my child's rights to an education under Article 9, Section 1 of the Idaho Constitution if my child is excluded from school during a disease outbreak.

_____ Name of Parent/Guardian (PRINT)	_____ Signature of Parent/Guardian	_____ Date
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_____ Full Name of Exempted Child (PRINT)	_____ Child's Date of Birth (Month, Day, Year)
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OPTIONAL: Parents/guardians may include a signed written statement regarding religious/other exemptions on the back/Page 2 of this document.

OPTIONAL STATEMENT:

As the child's parent/guardian, I exempt my child from school immunizations for the following reason(s):

Name of Parent/Guardian (PRINT)

Signature of Parent/Guardian

Date