

*Page 11: 2018-2019*

**RELIGIOUS EXEMPTION TO VACCINATION (S): Residential & Non-Residential Students**

(IF APPLICABLE)

* The top portion of this page is required **ONLY** if your child has a religious exemption to any vaccine

**Student’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Due to our **religious beliefs,** the following vaccines are incomplete or missing for our child (please circle all vaccines that apply):

|  |  |
| --- | --- |
| Hepatitis A | Hepatitis B |
| Chicken Pox/Varicella | Measles/Mumps/Rubella (MMR) |
| Meningitis (MCV4 or Men B) | Polio (OPV or IPV) |
| Tetanus/Diphtheria/Pertussis (Dtap/DT/TD/Tdap) |  |

* I, the parent/guardian, understand that my child may be excluded from school in the event of an outbreak of a vaccine preventable disease for which he/she is not vaccinated.
* I, the parent/guardian, understand that exclusion includes the dorm, school, and after-school activities, such as sporting events, dances, and graduation.
* I, the parent/guardian, understand that my child may be required to stay home for multiple weeks during an outbreak of a vaccine preventable disease for which he/she is not vaccinated.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature Parent/Guardian Printed Name Date**

**MEDICAL EXEMPTION TO VACCINATION (S): Residential & Non-Residential Students**

* This portion of the page is required **ONLY** if your child has a medical exemption to any vaccine

**Student’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician: please complete all columns below in order to exempt this student from school immunization requirements:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Exempted****Vaccine** | **Reason for** **Exemption** | **Permanent or Temporary****Exemption****(please circle)** | **Date the** **Temporary Exemption****Ends (if applicable)** |
|  |  | Permanent or Temporary |  |
|  |  | Permanent or Temporary |  |
|  |  | Permanent or Temporary |  |
|  |  | Permanent or Temporary |  |
|  |  | Permanent or Temporary |  |
|  |  | Permanent or Temporary |  |
|  |  | Permanent or Temporary |  |

Please place any additional information/comments here:

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*CC: Tina Brinkman, RN/Nikki Al Khatib, RN*