

Certificate of Immunization

Name _____

Birthdate _____

Address _____

Phone _____

Parent/Guardian (print) _____

Vaccine (Circle appropriate item)	Doses Enter month, day, and year each immunization was given				
Diphtheria & Tetanus (DTaP, DTP, Td or DT)	1 _____	2 _____	3 _____	4 _____	5 _____
Polio (OPV or IPV)	1 _____	2 _____	3 _____	4 _____	
Hepatitis B	1 _____	2 _____	3 _____		
Measles-Mumps-Rubella (MMR)	1 _____	2 _____			
Varicella (Vaccine or Disease)	1 _____	2 _____			
Other	1 _____	2 _____			

Signed _____

Date _____

(Physician, Public Health Official, School Nurse, or their designee)

Statement of Exemptions to Immunization Law

MEDICAL EXEMPTION

The physical condition of the above named child is such that immunization would endanger life or health.

Signed _____

Date _____

(Physician)

RELIGIOUS EXEMPTION

(Includes a strong moral or ethical conviction similar to a religious belief)

Parent of guardian of the above named child adheres to a religious belief whose teachings are opposed to such immunizations.

State your reason for requesting a religious exemption: _____

Signed _____

Date _____

(Parent OR Guardian)

Signed _____

(Signature of Notary and Seal)

* Notary required only if Exemption is Declared