Child's Name: _____

IDAHO CERTIFICATE OF IMMUNIZATION EXEMPTION

School Immunization Requirement

The Idaho Department of Health and Welfare strongly supports immunization as one of the easiest and most effective tools in preventing serious communicable diseases. These vaccine-preventable diseases can cause serious illness and even death. The Idaho Department of Health and Welfare also recognizes that individuals have the right to make the decision whether or not to vaccinate their children.

SECTION 1: ***Please read the following statements, check the box(es), and initial and date each statement regarding vaccine-preventable diseases for which an exemption is claimed. Sections 1 and 2 must be completed for this exemption to be valid.***

☐ **Diphtheria (DTaP, Tdap, Td):** I understand by not receiving this vaccine, my child is at increased risk of developing diphtheria. Serious symptoms and effects of this disease include: heart complications, paralysis, respiratory complications, coma, and death. _____ Initial _____ Date

☐ **Tetanus (DTaP, Tdap, Td):** I understand by not receiving this vaccine, my child is at increased risk of developing tetanus. Serious symptoms and effects of this disease include: seizures, laryngospasm, neuromuscular disease, and death. _____ Initial _____ Date

☐ **Pertussis (Whooping Cough) (DTaP, Tdap):** I understand by not receiving this vaccine, my child is at increased risk of developing pertussis. Serious symptoms and effects of this disease include: pneumonia, seizures, inflammation of the brain, neurological complications, and death. _____ Initial _____ Date

☐ **Polio:** I understand by not receiving this vaccine, my child is at increased risk of developing polio. Serious symptoms and effects of this disease include: paralysis, permanent disability, and death. _____ Initial _____ Date

☐ **Measles (MMR):** I understand by not receiving this vaccine, my child is at increased risk of developing measles. Serious symptoms and effects of this disease include: pneumonia, encephalitis, seizures, and death. _____ Initial _____ Date

☐ **Mumps (MMR):** I understand by not receiving this vaccine, my child is at increased risk of developing mumps. Serious symptoms and effects of this disease include: meningitis, inflammation of the testicles or ovaries, sterility, pancreatitis, deafness, and death. _____ Initial _____ Date

☐ **Rubella (German Measles) (MMR):** I understand by not receiving this vaccine, my child is at increased risk of developing rubella. Serious symptoms and effects of this disease include: encephalitis, arthritis, and neuritis. Congenital infection can result in deafness, heart defects, mental retardation, liver and spleen damage, and death. _____ Initial _____ Date

☐ **Hepatitis B:** I understand by not receiving this vaccine, my child is at increased risk of developing hepatitis B. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), life-long liver problems, such as scarring and liver cancer, and death. _____ Initial _____ Date

☐ **Varicella (Chickenpox):** I understand by not receiving this vaccine, my child is at increased risk of developing varicella. Serious symptoms and effects of this disease include: severe skin infections, pneumonia, brain damage, encephalitis, and death. _____ Initial _____ Date

☐ **Varicella Disease History:** My child has had chickenpox, but was <u>not</u> diagnosed by a physician. I decline to have my child receive the varicella vaccine and thus request a philosophical exemption from this requirement. _____ Initial _____ Date

☐ **Hepatitis A:** I understand by not receiving this vaccine, my child is at increased risk of developing hepatitis A. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), hospitalization, and even death. _____ Initial _____ Date

☐ **Meningococcal:** I understand by not receiving this vaccine, my child is at increased risk of developing meningococcal disease. Serious symptoms and effects of this disease include: neurological damage, sepsis, permanent scarring or loss of limbs, and death. _____ Initial _____ Date

Please continue to complete Section 2

SECTION 2*: Please select ONE of the following exemption types for vaccines checked above.*

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

As the physician for _____, I certify that the physical condition of this child is such that the immunizations checked in Section 1 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

As the parent/guardian of _____, I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I acknowledge that I have read this document in its entirety and I fully understand it.

_____	_____	_____
Name of Parent/Guardian (PRINT)	Signature of Parent/Guardian	Date

_____	_____
Full Name of Exempted Child (PRINT)	Child's Date of Birth (Month, Day, Year)

☐ RELIGIOUS EXEMPTION

As the parent/guardian of _____, I certify that I am a member of a recognized religious organization which has doctrine that opposes immunizations for the following reason(s):

_____

_____

_____

_____

_____

I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I acknowledge that I have read this document in its entirety and I fully understand it.

_____	_____	_____
Name of Parent/Guardian (PRINT)	Signature of Parent/Guardian	Date

_____	_____
Full Name of Exempted Child (PRINT)	Child's Date of Birth (Month, Day, Year)

☐ PHILOSOPHICAL EXEMPTION

As the parent/guardian of _____, I am opposed to having my child receive the immunization(s) checked in Section 1 of this form for the following reason(s):

_____

_____

_____

_____

_____

I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak, both for his/her own protection and for the protection of others. I acknowledge that I have read this document in its entirety and I fully understand it.

_____	_____	_____
Name of Parent/Guardian (PRINT)	Signature of Parent/Guardian	Date

_____	_____
Full Name of Exempted Child (PRINT)	Child's Date of Birth (Month, Day, Year)