REFUSAL OF IMMUNIZATION
For Medical Reasons

As the physician of:

Child's Last Name	*First Name*	*Age*
/ /		
Birth Date (mm/dd/yyyy)	*School*	*Grade*

I have elected to not immunize this student against the following disease(s):

- *Each disease for which a vaccine has not been administered must be checked. Parent / guardian must submit dates of immunization for all other diseases.*

Diphtheria ..... ☐
Tetanus ..... ☐
Pertussis ..... ☐
Polio ..... ☐
Measles (Rubeola) ..... ☐
Mumps ..... ☐
Rubella (German Measles) ..... ☐
Hepatitis B ..... ☐
Varicella ..... ☐
Pneumococcal Conjugate ..... ☐
HIB (Haemophilus Influenzae Type b) ..... ☐

In my opinion, this immunization would be injurious to the health and well-being of :

The student ..... ☐
A member of the student's household or family ..... ☐

Comments: _____

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_____ _____

Signature of Physician *Date*