8511.1 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:

_____

Signature of Physician *Date*