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) .... ☐
- Hep A .... ☐
- Rotavirus .... ☐

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*