

## REFUSAL OF IMMUNIZATION For Medical Reasons

As the physician of:

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Child's Last Name	First Name	Age
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Birth Date	School	Grade
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**A. I have elected to not immunize this student against the following disease(s): (check box\*)**

- Diphtheria .....
- Tetanus .....
- Pertussis .....
- Polio .....
- Measles (Rubeola) .....
- Mumps .....
- Rubella (German Measles).....
- Hepatitis B.....
- Varicella (chickenpox) .....

**In my opinion, this/these immunization(s) 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
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\* Each disease for which a vaccine has not been administered must be checked.  
Parent / guardian must submit dates of immunization for all other diseases.  
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