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 infectious 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. If you have any questions about the benefits and risks of immunization, please contact your healthcare provider or local health department.

SECTION 1: ***Please read the following statements, check the box(es), 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, DT, Tdap, Td):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing diphtheria if exposed to this disease. Serious symptoms and effects of this disease include: heart failure, paralysis (can't move parts of the body), breathing problems, coma, and death. _____ Date

☐ **Tetanus (DTaP, DT, Tdap, Td):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing tetanus if exposed to this disease. Serious symptoms and effects of this disease include: "locking" of the jaw, difficulty in swallowing and breathing, seizures (jerking and staring), painful tightening of muscles in the head and neck, and death. _____ Date

☐ **Pertussis (Whooping Cough) (DTaP, Tdap):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing pertussis (whooping cough) if exposed to this disease. Serious symptoms and effects of this disease include: severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures (jerking and staring), brain damage, and death. _____ Date

☐ **Polio:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing polio if exposed to this disease. Serious symptoms and effects of this disease include: paralysis (can't move parts of the body), meningitis (infection of the brain and spinal cord covering), permanent disability, and death. _____ Date

☐ **Measles, Mumps, Rubella (MMR):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing measles, mumps, and/or rubella if exposed to these diseases. Serious symptoms and effects of measles include: pneumonia, seizures (jerking and staring), brain damage, and death. Serious symptoms and effects of mumps include: meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, sterility, deafness, and death. Serious symptoms and effects of rubella include: rash, arthritis, and muscle or joint pain. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, and mental retardation. _____ Date

☐ **Hepatitis B:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis B if exposed to this disease. 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. _____ Date

☐ **Varicella (Chickenpox):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing varicella (chickenpox) if exposed to this disease. Serious symptoms and effects of this disease include: severe skin infections, pneumonia, brain damage, and death. A person who has had chickenpox can get a painful rash called shingles years later. _____ Date

☐ **Varicella Disease History:** I believe that my child has had chickenpox, but was <u>not</u> diagnosed by a licensed health care professional. _____ Date

☐ **Hepatitis A:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis A if exposed to this disease. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), "flu-like" illness, hospitalization, and death. _____ Date

☐ **Meningococcal:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing meningococcal disease if exposed to this disease. Serious symptoms and effects of this disease include: meningitis (infection of the covering of the brain and spinal cord), blood infections, loss of arms or legs**,** problems with nervous system, deafness, mental retardation, seizures (jerking and staring), strokes, and death. _____ Date

Please continue to complete Section 2

SECTION 2*: Please select ONE of the following exemption types (medical, religious, philosophical) for vaccines checked in Section 1.*

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

As the child's physician, I certify that the physical condition of this child is such that the immunization(s) 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 child's parent/guardian, 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.

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 child's parent/guardian, 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.

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 child's parent/guardian, 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.

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

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