

# REFUSAL OF IMMUNIZATION For Medical Reasons

As the physician of:

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

**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:** \_\_\_\_\_  
\_\_\_\_\_

<i>Signature of Physician</i>	<i>Date</i>
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