

**REFUSAL OF IMMUNIZATION
For Medical Reasons**

As the physician of:

Child's Last Name	First Name	Age
-------------------	------------	-----

Birth Date	School	Grade
------------	--------	-------

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 _____

Signature of Physician

Date

* Each disease for which a vaccine has not been administered must be checked.
Parent / guardian must submit dates of immunization for all other diseases.