

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)

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: _____

Signature of Physician

Date