

Child's Name: \_\_\_\_\_

## IDAHO SCHOOL IMMUNIZATION REQUIREMENTS EXEMPTION

In the event of a disease outbreak, a child exempted from Idaho school immunization requirements may be excluded from school for the duration of the outbreak. Please check the box(es) below, and date each line regarding all vaccine-preventable diseases for which an exemption is claimed.

- |  |       |      |  |       |      |
|--|-------|------|--|-------|------|
| <input type="checkbox"/> Diphtheria (DTaP, Tdap, Td)             | _____ | Date | <input type="checkbox"/> Hepatitis B   | _____ | Date |
| <input type="checkbox"/> Tetanus (DTaP, Tdap, Td)                | _____ | Date | <input type="checkbox"/> Hepatitis A   | _____ | Date |
| <input type="checkbox"/> Pertussis (Whooping Cough) (DTaP, Tdap) | _____ | Date | <input type="checkbox"/> Meningococcal   | _____ | Date |
| <input type="checkbox"/> Measles (MMR)                           | _____ | Date | <input type="checkbox"/> Varicella (Chickenpox)  | _____ | Date |
| <input type="checkbox"/> Mumps (MMR)                             | _____ | Date | <input type="checkbox"/> Varicella Disease History: My child has had chickenpox but was not diagnosed by a licensed healthcare professional. | _____ | Date |
| <input type="checkbox"/> Rubella (German Measles) (MMR)          | _____ | Date | <input type="checkbox"/> All required immunizations  | _____ | Date |
| <input type="checkbox"/> Polio                                   | _____ | Date |  |       |      |

I decline to provide details regarding my child's exemption status. **NOTE:** Your child will be considered exempt from all required school immunizations.

### 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 above 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. By signing this form, I am not waiving any of my child's rights to an education under Article 9, Section 1 of the Idaho Constitution if my child is excluded from school during a disease outbreak.

\_\_\_\_\_  
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/OTHER EXEMPTION

As the child's parent/guardian, I am exempting for religious or other reasons. I understand that in the event of a disease outbreak my child may be excluded from school for the duration of the outbreak. By signing this form, I am not waiving any of my child's rights to an education under Article 9, Section 1 of the Idaho Constitution if my child is excluded from school during a disease outbreak.

\_\_\_\_\_  
Name of Parent/Guardian (PRINT)

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Full Name of Exempted Child (PRINT)

\_\_\_\_\_  
Child's Date of Birth (Month, Day, Year)

*OPTIONAL: Parents/guardians may include a signed written statement regarding religious/other exemptions on the back/Page 2 of this document.*

**OPTIONAL STATEMENT:**

As the child's parent/guardian, I exempt my child from school immunizations for the following reason(s):

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\_\_\_\_\_  
Name of Parent/Guardian (PRINT)

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date