PERSONAL BELIEFS EXEMPTION TO REQUIRED IMMUNIZATIONS

STUDENT NAME (LAST, FIRST, MIDDLE)	GENDER ☐ M ☐ F	BIRTHDATE MONTH DAY YEAR __ __ / __ __ / __ __ __ __	TELEPHONE NUMBER
PARENT/GUARDIAN – NAME		ADDRESS	

A. AUTHORIZED HEALTH CARE PRACTITIONER LICENSED IN CALIFORNIA – FILL OUT THIS SECTION

I am a (check one): ☐ M.D./D.O. ☐ Nurse Practitioner ☐ Physician Assistant ☐ Naturopathic Doctor ☐ Credentialed School Nurse

Provision of information: I have provided the parent or guardian of the student named above, the adult who has assumed responsibility for the care and custody of the student, or the student if an emancipated minor, with information regarding 1) the benefits and risks of immunization and 2) the health risks to the student and to the community of the communicable diseases for which immunization is required in California (immunizations listed in Table below).

Signature of authorized health care practitioner

Date - within 6 months before entry to child care or school

Practitioner name, address, telephone number:

B. PARENT OR GUARDIAN – FILL OUT THESE SECTIONS

I. Check one of the boxes below:

☐ **Receipt of information:** I have received information provided by an authorized health care practitioner regarding 1) the benefits and risks of immunization and 2) the health risks to the student named above and to the community of the communicable diseases for which immunization is required in California (immunizations listed in Table below).

☐ **Religious beliefs**: I am a member of a religion which prohibits me from seeking medical advice or treatment from authorized health care practitioners. (Signature of a health care practitioner not required in Part A.)

Signature of parent or guardian **Date - within 6 months before entry to child care or school**

II. AFFIDAVIT

Immunizations already received: I have provided the child care or school with a record of all immunizations the student has received that are required for admission (California Health and Safety Code §120365).

Immunizations for which exemption is requested: An unimmunized student and the student's contacts at school and home are at greater risk of becoming ill with a vaccine-preventable disease. I understand that an unimmunized student may be excluded from attending school or child care during an outbreak of, or after exposure to, any of these diseases for the protection of the student and others (17 CCR §6060). I hereby request exemption of the student named above from the required immunizations checked below because such immunization is contrary to my beliefs.

School Category	Table of Required Immunizations – Check box(es) to request exemption.
Child Care Only	☐ ***Haemophilus influenzae* type b** (Hib meningitis)
Child Care and K-12th Grade	☐ **DTaP** (Diphtheria, Tetanus, Pertussis [whooping cough]) ☐ **Hepatitis B** ☐ **MMR** (Measles, Mumps, Rubella) ☐ **Polio** ☐ **Varicella** (Chickenpox)
7th Grade Advancement (or admission at 7-12th Grade)	☐ **Tdap** (Tetanus, reduced Diphtheria, Pertussis [whooping cough])

Signature of parent or guardian **Date**

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