# REFUSAL OF IMMUNIZATION
## For Medical Reasons

**As the physician, physician assistant or advanced practice registered nurse 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.*

- Diptheria ………………………………………………………….. ☐
- Tetanus ………………………………………………………….. ☐
- Pertussis ………………………………………………………….. ☐
- Polio ………………………………………………………….. ☐
- Measles (Rubeola) ………………………………………………….. ☐
- Mumps ………………………………………………………….. ☐
- Rubella (German Measles) ……………………………………….. ☐
- Hepatitis B ………………………………………………………….. ☐
- Varicella ………………………………………………………….. ☐
- Pneumococcal Conjugate ……………………………………….. ☐
- HIB (Haemophilus Influenza 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:** ______________________________________________________________

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*Signature of health care professional listed above* *Date*