REFUSAL OF IMMUNIZATION
For Medical Reasons

As the physician of:

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<tr>
<th>Child's Last Name</th>
<th>First Name</th>
<th>Age</th>
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<tr>
<th>Birth Date (mm/dd/yyyy)</th>
<th>School</th>
<th>Grade</th>
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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 _____________