PARENTAL OR MEDICAL WAIVER FOR IMMUNIZATIONS

Student's Name ______________________________ Birthdate __________

School Grade

Parent/Guardian Name ______________________________

Parent/Guardian Address ______________________________ Phone ( )________

The above named student has not received the required immunizations against the specific disease(s) checked below. Please state reason why student was not immunized.

_____ MCV 4

_____ Measles (Rubeola) ______________________________

_____ German Measles (Rubella) ______________________________

_____ Mumps ______________________________

_____ Diphtheria ______________________________

_____ Tetanus ______________________________

_____ Pertussis (Whooping Cough)

_____ Polio ______________________________

_____ 2nd MMR

_____ Hepatitis B ______________________________

_____ VARICELLA _____ Tdap

If student is not immunized for medical reasons, physician's signature is required.

Signed: ______________________________ Date __________

Parent/Guardian

Parent Agreement

I understand that, in the event of an outbreak of any disease checked above, the student named above will be subject to exclusion from school for the duration of the outbreak. Unless provided a statement, signed by the physician, verifying the student has had the disease in question, the student cannot attend school until at least two weeks after the last reported case occurs. (A physician diagnosed history of disease is accepted for measles and mumps only. A positive laboratory test is the only acceptable proof of having had rubella.)

Signed: ______________________________ Date __________

Parent/Guardian

This document must be kept on file with the above student's permanent health record.

Please return by ______________ to the attention of the school nurse.