______________________________________ *Patient ID number*
______________________________________ *Patient Name*

IMMUNIZATION RELIGIOUS EXEMPTION FORM

INSTRUCTIONS TO PARENTS OR GUARDIANS:

Vaccine preventable diseases continue to exist. Immunizations are one of the most cost effective measures to protect children, adolescents, and adults from harmful vaccine preventable diseases and possible death. A high proportion of children and adolescents must be immunized to prevent outbreaks of disease in school settings and other places where children and adolescents are educated, work, and play close together.

A parent or guardian wishing to exempt their child from some or all vaccinations must provide a written statement indicating the religious objections to the vaccination(s). A person who has been exempted from a vaccination is considered susceptible to the disease or diseases for which the vaccination offers protection. This person may be subject to exclusion from school, group facilities or other programs, if the local and/or state public health authority advises exclusion as a disease control measure.

By signing this religious exemption form, I acknowledge that I have been educated and received materials regarding the benefits of vaccination. I have had an opportunity to ask questions which were answered to my satisfaction. I further acknowledge that I may be placing myself or my child and others at risk of serious illness should my child contract a disease that could have been prevented through proper vaccination. I feel I understand the risks associated with not receiving the vaccines checked below. I also give permission to share my immunization record and /or Certificate of Religious Exemption with facilities or institutions, which are required by law to have such records and with my other health care provider(s).

PLEASE PRINT

All information must be filled in below:

I swear or affirm that I object to having my child, named ______________________________________,

date of birth____________________________, immunized with the vaccines that I have checked below:

- ☐ DTaP, DT, Td, Tdap (Diphtheria, Tetanus, acellular Pertussis)
- ☐ *Haemophilus influenzae* type b
- ☐ Hepatitis B
- ☐ Meningococcal
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ Pneumococcal Conjugate
- ☐ Polio
- ☐ Varicella (chickenpox)

Reason: ____

Parent(s)/Guardian(s) Name(s): ____

____	____________________
Signature of parent, or guardian	*Date signed*
____	____________________
Signature of physician, APRN, PA, pharmacist, LHD administrator, or RN designee	*Date signed*