

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.

_____ Measles (Rubeola) _____

_____ German Measles (Rubella) _____

_____ Mumps _____

_____ Diphtheria _____

_____ Tetanus _____

_____ Pertussis (Whooping Cough) _____

_____ Polio _____

_____ 2nd MMR _____

_____ Hepatitis B _____

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.