CERTIFICATE OF EXEMPTION

Please read instructions on the reverse of this certificate before completing.
All entries must be legible or form will be returned. Please print unless signature is required.

Name of Child (Last, First, MI) | Birth Date | Birth Country | Birth State

Parent or Guardian's Name | Mother's Maiden Name | Parent's Street Address

County | City | State | Zip Code | Parent Phone Number

Name of School, Child Care Facility or Head Start | School District | School Year | School Grade | Facility Phone Number

Race (select up to 3): ☐ Alaskan Native or American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other

Ethnicity (select 1): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Child's Gender: ☐ Male ☐ Female

TYPE OF EXEMPTION

(Complete either section 1, 2 or 3 and sections 4 & 5)

1. MEDICAL CONTRAINDICATION:

I hereby certify that the immunization(s) specified below are medically contraindicated for the above-named child.

Immunization(s) | State the condition that would endanger the life or health of the child.

Printed name of Physician | Signature of Physician

Address of Physician | Phone number of Physician

2. RELIGIOUS OBJECTION:

I hereby certify that immunization is contrary to the teachings of the above-named child's religion.

Printed name of Religious Leader or Parent/Guardian | Signature of Religious Leader or Parent/Guardian

3. PERSONAL OBJECTION:

I hereby certify that immunization is contrary to my beliefs. As the parent or legal guardian of the above-named child, I request an exemption to the immunization requirements for School, Child Care Facility or Head Start attendance. I have written a brief summary of my objections in the space provided below. **I understand that lost records are not grounds for an exemption.**

REQUIRED: Summary of Objections: *(Limited to 600 characters.)*

4. Please check which immunizations this exemption applies to:

☐ DTaP/Td/Tdap (Diphtheria, Tetanus & Pertussis) ☐ Hib (Haemophilus Influenzae type B) ☐ Polio

☐ Hepatitis A ☐ MMR (Measles, Mumps and Rubella) ☐ Varicella (Chickenpox)

☐ Hepatitis B ☐ Pneumococcal ☐ All

5. Acknowledgement

I understand that in the event of a disease outbreak in the School, Child Care Facility or Head Start, my child may be excluded for his/her protection and for the protection of other children in the School, Child Care Facility or Head Start.

Printed name of Parent/Guardian | Signature of Parent/Guardian | Date

ATTENTION: **Please submit this completed form to the Immunization Service.**

Oklahoma State Department of Health
Immunization Service
123 Robert S Kerr, Suite 1702
Oklahoma City, Oklahoma 73102-6406

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