

Request For Exemption To Immunization
Head Start and Early Head Start

If you wish for your child to be exempt from the immunization requirements, this form must be completed, signed and returned to the child's Family Advocate. As stated in Indiana State Code IC 20-34-4-2, your child will not be allowed to attend child care until either a record of immunization or this exemption statement is submitted with all required information. **In the event of an outbreak of a vaccine preventable disease for which you can not provide proof of immunity of your child, your child will not be allowed to attend the center until the risk period ends.**

Medical Reasons – If the immunization would be a health risk to the child because of pre-existing medical conditions, you must sign the statement below *along with your physician=s signature*. Your physician must state the reason for the medical exemption. The exemption may be for one or more vaccines, and may be either permanent or temporary. If the condition is temporary, the date of its end must be given, at which time the child must receive any necessary vaccine doses.

Religious Beliefs – If immunizations are against your religious beliefs, you must sign below to exempt your child from the requirements.

Laboratory Evidence – If your child has previously had a vaccine preventable disease, immunization against that disease is not required if laboratory evidence of immunity sign by a physician can be provided. *Copies of lab results must accompany this request.*

Complete And Return This form To Your Family Advocate

I hereby request an exemption from the immunization requirements for the child listed below, have received information about immunization and understand the risks and possible outcomes of this decision.

Childs Name _____ Date of Birth _____
(month, day, year)

Type of exemption requests: (Mark one)	For the following vaccines: (Mark all that apply)
<input type="checkbox"/> Medical* (See below)	<input type="checkbox"/> Diphtheria <input type="checkbox"/> Tetanus <input type="checkbox"/> Pertussis <input type="checkbox"/> Varicella
<input type="checkbox"/> Religious Beliefs	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella
<input type="checkbox"/> Laboratory Evidence	<input type="checkbox"/> Polio <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis A
	<input type="checkbox"/> Haemophilus Influenzae type b

*If a medical exemption is marked, complete the following:

Reason for medical exemption: _____ Length of exemption: _____
_____ Permanent _____ Temporary until: _____

Required Signatures: Parent or guardian must sign all requests and physician must also sign any requests for medical or laboratory evidence exemptions.

Parent or Guardian

Physician

Printed Name

Printed Name

Date: Month, Day, Year

Date: Month, Day, Year