CHILD'S NAME: _____ DATE OF BIRTH: _____/_____/_____
Full name of Child (Print) mm dd yyyy

Immunization Documentation Requirements Exemption Form

For Preschool & K-12

Exemption(s) Being Claimed:
Idaho Statute permits a parent or guardian to exempt their child from school immunization requirements based on medical, religious, or other grounds (Section 39-4801). Please check the box(es) below for each immunization an exemption is being claimed for:

Vaccine Types	Exemption Type Claimed
Diphtheria, Tetanus, Pertussis (DTaP)	☐ Medical ☐ Religious/Other
Hepatitis A	☐ Medical ☐ Religious/Other
Hepatitis B	☐ Medical ☐ Religious/Other
Measles, Mumps and Rubella (MMR)	☐ Medical ☐ Religious/Other
Meningococcal (MenACWY)	☐ Medical ☐ Religious/Other
Polio (IPV)	☐ Medical ☐ Religious/Other
Tetanus, Diphtheria, Pertussis (Tdap) Booster	☐ Medical ☐ Religious/Other
Varicella (Chickenpox)	☐ Medical ☐ Religious/Other ☐ My child has had Chickenpox, but it was not diagnosed by a healthcare provider

☐ **I decline to provide details regarding my child's immunization status.**
NOTE: Your child will be considered exempt from all school immunizations.

If a medical exemption was claimed above, have your child's licensed healthcare provider complete the Medical Exemption section below. If a Religious/Other exemption was claimed above, the parent/guardian should complete the Religious/Other Exemption section below.

☐ **Medical Exemption: The signature of a licensed healthcare provider is required in the space below if any Medical Exemptions are being claimed.**

As the child's licensed healthcare provider, I certify that the physical condition of this child is such that the immunization(s) listed below would endanger the life or health of the child.

☐ This medical exemption is permanent.
☐ This medical exemption if temporary. Duration of the temporary exemption through: _____/_____/_____
mm dd yyyy

I hereby request that this child be exempted from the School Immunization Documentation Requirements due to a medical condition for which immunizations are contraindicated (39-4801).

_____ _____ _____/_____/_____
Name of Licensed Healthcare Provider (Print) Signature of Licensed Healthcare Provider mm dd yyyy

Required Signature of Parent or Guardian:
As the child's parent or guardian, I request that my child be exempted from the vaccination(s) checked above.

_____ _____ _____/_____/_____
Name of Parent of Guardian (Print) Signature of Parent or Guardian mm dd yyyy

Optional Statement:
As the child's parent or guardian, I exempt my child from school immunization requirements for the following reason(s):