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* | *Name of School / Child Care Facility / Head Start*

Parent/Guardian's Name | *School Year* | *Grade* | *Facility Phone Number* | *School District*

Parent Phone Number | *County* | *City* | *Zip*

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)
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hib (Haemophilus Influenzae type B)
- ☐ MMR (Measles, Mumps and Rubella)
- ☐ Pneumococcal
- ☐ Polio
- ☐ Varicella (Chickenpox)
- ☐ 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 have to be excluded for his/her protection and for the protection of the other children in the School, Child Care Facility or Head Start.

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

ATTENTION: PARENT/GUARDIAN – This form is to be submitted to the School, Child Care Facility or Head Start.

The School, Child Care Facility or Head Start should keep a copy of this form and mail the original to:

Oklahoma State Department of Health
Immunization Service - 0306
1000 N.E. 10th Street
Oklahoma City, Oklahoma 73117-1299

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For Questions Call: 405-271-4073
For forms, visit: http://imm.health.ok.gov