



PROOF OF IMMUNIZATION REQUIREMENT OR EXEMPTION FOR SCHOOL ENTRY

DEPARTMENT OF HEALTH

ONLY ONE SECTION SHOULD BE FILLED

Name of Child, Date of Birth (D, M, Y), Medicare Number

Parent or Guardian, School District No.

Address, Postal Code

1. PROOF OF IMMUNIZATION

This is to verify that the above-named child has received the following immunizations:

Three doses of Polio vaccine, Three doses of D.P.T. or D.T. vaccine, One dose of Measles, Mumps and Rubella Vaccine

Comments:

Date, Signature of Physician or Public Health Nurse

2. MEDICAL EXEMPTION

A. The following immunizations are harmful to this child's health and I recommend that they not be given

B. I observed this child while he / she experienced the following illness(es). Vaccine designed to protect against the disease(s) named is not necessary.

Date, Signature Physician

3. DECLARATION OF OBJECTION TO IMMUNIZATION

I object to the administration of vaccines to my child named above and therefore request exemption from the requirements as provided for in the Education Act. I understand that my child will be excluded from school in the event of an outbreak of one of the infectious diseases.

Date, Signature of Parent or Guardian