



# State of Idaho CERTIFICATE OF EXEMPTION

Child's Name \_\_\_\_\_ Child's Birth date \_\_\_\_\_

I \_\_\_\_\_, as the parent or guardian of \_\_\_\_\_,  
Parent/Guardian Name Child's Name

### A. CHECK THE BOX(ES) FOR WHICH AN EXEMPTION IS BEING CLAIMED

- DTaP    Polio    MMR    Hepatitis B    Hib    Varicella    Hepatitis A    Pneumococcal    Influenza    Rotavirus  
 Human Papillomavirus    Meningococcal

*In the event of a disease outbreak your child may be excluded from Child Care or School. The period of exclusion may be for a few days up to several months and may extend to two incubation periods after the last case depending upon the disease and the number of cases.*

Please read the following statements and initial each statement regarding vaccine preventable diseases for which an exemption is being claimed.

**Diphtheria (DTaP, Tdap, Td):** I understand by not receiving the Diphtheria vaccine, my child is at risk of developing a sore throat, low-grade fever, heart complications, paralysis, respiratory complications, coma and even death.

\_\_\_\_\_  
Initial Date

**Tetanus (DTaP, Tdap, Td):** I understand by not receiving the Tetanus vaccine, my child is at risk of developing seizures and possible fatal neuromuscular disease.

\_\_\_\_\_  
Initial Date

**Pertussis (Whooping Cough) (DTaP, Tdap):** I understand by not receiving the Pertussis vaccine, my child is at risk of developing pneumonia, seizures, inflammation of the brain, neurological complications and even death.

\_\_\_\_\_  
Initial Date

**Polio:** I understand by not receiving the Polio vaccine, my child is at risk of developing a fever, sore throat, nausea, headaches, stomachaches, stiffness, and paralysis that can lead to permanent disability and death.

\_\_\_\_\_  
Initial Date

**Measles (MMR):** I understand by not receiving the Measles vaccine, my child is at risk of developing a rash, high fever, cough, runny nose, red, watery eyes, diarrhea, ear infections, pneumonia, encephalitis, seizures, and death.

\_\_\_\_\_  
Initial Date

**Mumps (MMR):** I understand by not receiving the Mumps vaccine, my child is at risk of developing a fever, headache, muscle aches, swelling of the lymph nodes close to the jaw, meningitis, inflammation of the testicles or ovaries, sterility, arthritis, inflammation of the pancreas and deafness (usually permanent).

\_\_\_\_\_  
Initial Date

**Rubella (German Measles) (MMR):** I understand by not receiving the Rubella vaccine, my child is at risk of developing a rash and fever in children and young adults, birth defects if acquired while pregnant include deafness, cataracts, heart defects, mental retardation, and liver and spleen damage.

\_\_\_\_\_  
Initial Date



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**Hepatitis B:** I understand by not receiving the Hepatitis B vaccine, my child is at risk of developing yellow skin or eyes, tiredness, stomachaches, loss of appetite, nausea, or joint pain, life-long liver problems, such as scarring of the liver and liver cancer.

\_\_\_\_\_  
Initial                      Date

**Haemophilus Influenza type b (Hib):** I understand by not receiving the Hib vaccine, my child is at risk of developing skin and throat infections, meningitis, pneumonia, sepsis, arthritis, permanent brain damage and even death.

\_\_\_\_\_  
Initial                      Date

**Varicella (Chickenpox):** I understand by not receiving the Varicella vaccine, my child is at risk of developing a rash, fever, severe skin infections, scars, pneumonia, brain damage or death.

\_\_\_\_\_  
Initial                      Date

**Hepatitis A:** I understand by not receiving the Hepatitis A vaccine, my child is at risk of developing jaundice (yellow skin or eyes), severe stomach pains and diarrhea, hospitalization and even death.

\_\_\_\_\_  
Initial                      Date

**Pneumococcal:** I understand by not receiving the Pneumococcal vaccine, my child is at risk of developing severe disease including meningitis, blood infections, pneumonia, deafness and brain damage.

\_\_\_\_\_  
Initial                      Date

**Influenza (flu):** I understand by not receiving the influenza vaccine, my child is at risk of developing a fever, cough, sore throat, chills, headache, muscle aches as a result of the influenza virus.

\_\_\_\_\_  
Initial                      Date

**Rotavirus:** I understand by not receiving the Rotavirus vaccine, my child is at risk of developing severe diarrhea and vomiting which can lead to dehydration and death.

\_\_\_\_\_  
Initial                      Date

**Human Papillomavirus (HPV):** I understand by not receiving the HPV vaccine, my child is at risk for a common virus that is spread through sexual contact. There are approximately 40 types of genital HPV, some types can cause cervical cancer in women and can also cause other kinds of cancer in both men and women.

\_\_\_\_\_  
Initial                      Date

**Meningococcal:** I understand by not receiving the meningococcal vaccine, my child is at risk for severe bacterial infection that can cause meningitis, bloodstream infection, and other localized infections.

\_\_\_\_\_  
Initial                      Date



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### B. TYPE OF EXEMPTION

- Medical (must have a physician's signature)     Personal (must have a signed statement from parent/guardian)     Religious (must have a signed statement from parent/guardian)

1. MEDICAL STATEMENT: I hereby certify that the physical condition of this child is such that the immunization(s) checked in Section A would endanger the life or health of the child. (This exemption requires the signature of a physician).

\_\_\_\_\_  
Physicians Signature

2. PERSONAL STATEMENT: I have investigated the risks of not vaccinating my child; nevertheless I have decided to not vaccinate my child for the following reason(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. RELIGIOUS STATEMENT: I have investigated the risks of not vaccinating my child; nevertheless I have decided to not vaccinate my child for the following reason(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I know that failure to follow the recommendations about vaccination may endanger the health or life of my child and others that my child might come in contact with. I acknowledge that I have read this document in its entirety and fully understand it.

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_