



# Dublin City School District

## Immunization Exemption

Students 5320 F2 Revised 12/1/17 English
---

- Section I to be completed by the parent/guardian.
- Section II to be completed by a health care provider if there is a medical exemption.
- Return to the school nurse upon completion.

---

### I. Parent/Guardian section

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ School: \_\_\_\_\_

As required under the Compulsory Immunization Law (Ohio Revised Code, Section 3313.67 and 3313.671), I hereby signify by my signature that I object for the reason stated below to the immunization of my child against the following disease(s):

- Polio     Diphtheria/Tetanus/Pertussis (DTP)     Measles     Mumps     Rubella  
 Hib     Hepatitis-B     Tdap     Varicella (Chickenpox)     Meningococcal

Reason for exemption: \_\_\_\_\_

I'm aware that my child is subject to exclusion from school as required by the Ohio Department of Health in the event of any outbreak of the communicable disease(s) that I have checked above, and that this exclusion may last for the duration of the outbreak, which could extend over a period of several weeks.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### II. Health care provider section

Please check contraindicated immunizations for medical exemption.

- Polio     Diphtheria/Tetanus/Pertussis (DTP)     Measles     Mumps     Rubella  
 Hib     Hepatitis-B     Tdap     Varicella (Chickenpox)     Meningococcal

Reason for medical exemption: \_\_\_\_\_

Time frame for medical exemption: \_\_\_\_\_

**Provider Signature/Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(ONLY required when this is a medical exemption)