Dublin City School District

Immunization Exemption

Students
5320 F2
Revised 12/1/17

- 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)