



# Mount Vernon City School District Immunization Exemption

As required by Ohio Law (Ohio Revised Code, Section 3313.67 and 3313.671)

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

## Religious and Good Cause Exemption

A pupil who presents a written statement of his/her parent or guardian, in which the parent or guardian objects to the immunization for good cause, including religious convictions, is not required to be immunized.

I understand that the law requires me to sign a waiver on my child taking immunization(s). 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  
 Hepatitis-B    
  MMR    
  Tdap    
  Varicella (Chickenpox)    
  Meningococcal

Reason for Exemption:

Religious: \_\_\_\_\_

Good Cause: Please Explain \_\_\_\_\_

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: \_\_\_\_\_

## Medical Exemption

A child whose physician certifies in writing that such immunization against this/these disease(s) is medically inadvisable, is not required to be immunized against that disease. This section does not limit or impair the right of a board of education of a city, exempted village, or local school district to make and enforce rules to secure immunization against polio, rubeola, rubella, diphtheria, pertussis, and tetanus of the pupils under its jurisdiction.

Please check inadvisable immunizations for a medical exemption:

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

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

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

Healthcare Provider Signature/Title: \_\_\_\_\_ Date: \_\_\_\_\_

(ONLY required when this is a medical exemption)