

Child's Name: \_\_\_\_\_

# IDAHO CHILDCARE IMMUNIZATION REQUIREMENTS EXEMPTION

In the event of a disease outbreak, a child exempted from Idaho childcare immunization requirements may be excluded from a childcare facility for the duration of the outbreak. Please check the box(es) below, and date each line regarding all vaccine-preventable diseases for which an exemption is claimed.

- |  |       |  |       |
|--|-------|--|-------|
| <input type="checkbox"/> Diphtheria (DTaP, Tdap, Td)             | _____ | <input type="checkbox"/> Haemophilus Influenza Type b (Hib)  | _____ |
|  | Date  |  | Date  |
| <input type="checkbox"/> Tetanus (DTaP, Tdap, Td)                | _____ | <input type="checkbox"/> Hepatitis A   | _____ |
|  | Date  |  | Date  |
| <input type="checkbox"/> Pertussis (Whooping Cough) (DTaP, Tdap) | _____ | <input type="checkbox"/> Rotavirus   | _____ |
|  | Date  |  | Date  |
| <input type="checkbox"/> Measles (MMR)                           | _____ | <input type="checkbox"/> Pneumococcal  | _____ |
|  | Date  |  | Date  |
| <input type="checkbox"/> Mumps (MMR)                             | _____ | <input type="checkbox"/> Varicella (Chickenpox)  | _____ |
|  | Date  |  | Date  |
| <input type="checkbox"/> Rubella (German Measles) (MMR)          | _____ | <input type="checkbox"/> <b>Varicella Disease History:</b> My child has had chickenpox but was <u>not</u> diagnosed by a licensed healthcare professional. | _____ |
|  | Date  |  | Date  |
| <input type="checkbox"/> Polio                                   | _____ |  | Date  |
|  | Date  |  |       |
| <input type="checkbox"/> Hepatitis B                             | _____ | <input type="checkbox"/> All required immunizations  | _____ |
|  | Date  |  | Date  |

I decline to provide details regarding my child's exemption status. **NOTE:** Your child will be considered exempt from all required childcare immunizations.

**MEDICAL EXEMPTION** (This exemption requires the signature of a licensed physician.)

As the child's physician, I certify that the physical condition of this child is such that the immunization(s) checked above would endanger the health of the child.

- This medical exemption is permanent.
- This medical exemption is temporary. Duration of temporary exemption: \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby request that this child be exempted from the Immunization Requirements for Children Attending Licensed Daycare Facilities (IDAPA 16.02.11) due to a medical condition for which immunizations are contraindicated.

_____ Name of Physician (PRINT)	_____ Signature of Physician	_____ Medical License #	_____ Date
------------------------------------	---------------------------------	----------------------------	---------------

As the child's parent/guardian, I understand that in the event of a disease outbreak my child may be excluded from childcare for the duration of the outbreak.

_____ Name of Parent/Guardian (PRINT)	_____ Signature of Parent/Guardian	_____ Date
--	---------------------------------------	---------------

_____ Full Name of Exempted Child (PRINT)	_____ Child's Date of Birth (Month, Day, Year)
--	---

**RELIGIOUS/OTHER EXEMPTION**

As the child's parent/guardian, I am exempting for religious or other reasons. I understand that in the event of a disease outbreak my child may be excluded from childcare for the duration of the outbreak.

_____ Name of Parent/Guardian (PRINT)	_____ Signature of Parent/Guardian	_____ Date
--	---------------------------------------	---------------

_____ Full Name of Exempted Child (PRINT)	_____ Child's Date of Birth (Month, Day, Year)
--	---

*OPTIONAL: Parents/guardians may include a signed written statement regarding religious/other exemptions on the back/Page 2 of this document.*

**OPTIONAL STATEMENT:**

As the child's parent/guardian, I exempt my child from childcare immunizations for the following reason(s):

---

---

---

---

---

---

---

\_\_\_\_\_  
Name of Parent/Guardian (PRINT)

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date