

CHILD'S NAME: \_\_\_\_\_  
Full name of Child (Print)

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

# Immunization Documentation Requirements Exemption Form For Preschool & K-12

## Exemption(s) Being Claimed:

Idaho Statute permits a parent or guardian to exempt their child from school immunization requirements based on medical, religious, or other grounds ([Section 39-4801](#)). Please check the box(es) below for each immunization an exemption is being claimed for:

Vaccine Types	Exemption Type Claimed
Diphtheria, Tetanus, Pertussis (DTaP)	<input type="checkbox"/> Medical <input type="checkbox"/> Religious/Other
Hepatitis A	<input type="checkbox"/> Medical <input type="checkbox"/> Religious/Other
Hepatitis B	<input type="checkbox"/> Medical <input type="checkbox"/> Religious/Other
Measles, Mumps and Rubella (MMR)	<input type="checkbox"/> Medical <input type="checkbox"/> Religious/Other
Meningococcal (MenACWY)	<input type="checkbox"/> Medical <input type="checkbox"/> Religious/Other
Polio (IPV)	<input type="checkbox"/> Medical <input type="checkbox"/> Religious/Other
Tetanus, Diphtheria, Pertussis (Tdap) Booster	<input type="checkbox"/> Medical <input type="checkbox"/> Religious/Other
Varicella (Chickenpox)	<input type="checkbox"/> Medical <input type="checkbox"/> Religious/Other <input type="checkbox"/> My child has had Chickenpox, but it was not diagnosed by a healthcare provider

I decline to provide details regarding my child's immunization status.

NOTE: Your child will be considered exempt from all school immunizations.

**Medical Exemption:** The signature of a licensed healthcare provider is required in the space below if any Medical Exemptions are being claimed.

As the child's licensed healthcare provider, I certify that the physical condition of this child is such that the immunization(s) listed below would endanger the life or health of the child.

This medical exemption is permanent.

This medical exemption is temporary. Duration of the temporary exemption through: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

I hereby request that this child be exempted from the School Immunization Documentation Requirements due to a medical condition for which immunizations are contraindicated ([39-4801](#)).

\_\_\_\_\_  
Name of Licensed Healthcare Provider (Print)

\_\_\_\_\_  
Signature of Licensed Healthcare Provider

\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

## Required Signature of Parent or Guardian (for any exemptions claimed above):

As the child's parent or guardian, I request that my child be exempted from the vaccination(s) checked above.

\_\_\_\_\_  
Name of Parent or Guardian (Print)

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

