PORTER COUNTY EDUCATION SERVICES
IMMUNIZATION WAIVER

Student _____ School _____

___ Within 20 calendar days, I will provide documentation from a doctor health department or previously attended school which certifies my child's immunization status. I understand that if this requirement is not met, my child will be excluded from school until the requested information is provided by me.

___ I agree to obtain the required immunizations according to the schedule listed. I will provide documentation of immunization to the school nurse. I understand my child may be excluded from school if I do not comply in a timely manner.

Schedule: _____

_____

___ I request exemption from complying with required immunizations for my child. *By Indiana Law: Only Religious Objection or Doctor Approved exemptions qualify.

My reason for objection to the required immunizations is _____

_____

___ I understand that in the event of disease outbreak the Department of Health may require nonimmunized students to be excluded from school until the period of communicability ends. I understand I am required to file an immunization waiver ANNUALLY. (Medical exemption also requires a doctor signature.)

Parent Signature _____ Date _____

Home Address _____ Phone _____

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___ Medical Exemption

The above named student is exempt from immunization for the following reason:

_____

Doctor's Signature _____ Date _____

Office Address _____ Phone _____