

IMMUNIZATION RECORD

Student Name: _____ Phone: () _____
School: _____ CIF: _____

LEGAL EXEMPTIONS TO MINNESOTA STATUTES 2003, SECTION 121A.15

1. No student under 15 months of age shall be required to be immunized against measles, mumps, and rubella.
2. No student 5 years of age or older shall be required to be immunized against Haemophilus Influenza Type b.
3. No student 7 years of age or older shall be required to be immunized against pertussis.
4. No student 18 years of age or older shall be required to be immunized against poliomyelitis.
5. No student shall be required to receive an immunization for which there is a medical contraindication. The following (or similar) statement must be signed by a physician in order to receive a medical exemption.

I here by certify that immunization is contraindicated for medical reasons for the following immunizations:

Signature of Physician

Date

6. No student shall be required to receive an immunization for which laboratory evidence of immunity exists.

I hereby certify that laboratory confirmation of the presence of adequate immunity exists for the following immunizations:

Signature of Physician

Date

7. No student shall be required to receive an immunization which is contrary to the conscientiously held beliefs of the parent or guardian. The following (or similar) statement must be signed and notarized in order for the student to receive an exemption.

I hereby certify by notarization that immunization for my child is contrary to my conscientiously held beliefs. Indicate vaccine(s):

Signature of Parent or Legal Guardian

Date

Subscribed and sworn to me this _____ day of _____ 20 _____

Signature of Notary

SPECIAL EXEMPTIONS

Children less than 7 years of age:

The 5th dose of DTP or 4th dose of Polio vaccine is not necessary if the 4th DTP or 3rd Polio was administered after the 4th birthday.

Children 7 years of age or older:

For children more than 7 years of age, 3 doses of DTP, DT, or Td vaccine and 3 doses of Polio vaccine are sufficient to meet the minimum requirements of the law.



IMMUNIZATION RECORD

Student's Last Name

First Name

MI

School

Birthdate

Dear Parent or Guardian:

Minnesota law requires children who are enrolled in school to be immunized against diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, Hepatitis B, and varicella. Students may be exempt from the law due to a conscientiously held objection by the parent, laboratory confirmation of immunity from the disease or medical contraindication.* Haemophilus Influenza b is required for children four years of age or under. This form provides the school with information required by the law.

UNLESS THE IMMUNIZATION(S) LISTED BELOW IS (ARE) OBTAINED, and documentation of your child's immunization or exemption is provided to the school, your child will not be allowed to start Kindergarten on the first day of school or proceedings will be started to exclude your child from school. We regret the necessity of taking such action and do not want to interrupt your child's education. However, state law requires complete immunization information for continued school enrollment. If you already have records to prove that your child has received the required immunizations or exemptions, please provide these to the school immediately. This information will be available for review by the Minnesota Department of Health.

Enter the **MONTH, DAY, and YEAR** in which the pupil received each of the following vaccines. **DO NOT USE (✓) or (X).**

Type of Vaccine	1 st Dose: MM/DD/YY	2 nd Dose: MM/DD/YY	3 rd Dose: MM/DD/YY	4 th Dose: MM/DD/YY	5 th Dose: MM/DD/YY
Diphtheria, Pertussis, Tetanus (DPT/DtaP)					
Tetanus, Diphtheria booster (Td) (Tdap ≥ age 7)					
Polio (IPV/OPV)					
Measles, Mumps, Rubella (MMR) / Minimum age on or after 1 st birthday					
Haemophilus Influenza B (HIB) / Not required for children > age 4					
Hepatitis B (HBV)				Legal Exemptions on Reverse Side	
Varicella (Chickenpox)					

Pnuemococcal (PCV) / Recommended, not required					
Human Papillomas Virus (HPV) / Recommended, not required					
Meningococcal Recommended, not required					

1. () I certify that the above named child has received the immunizations as required and is completely immunized as indicated above.

Signature of Health Care Provider () Phone _____ Date _____

2. () The above information has been transferred from records maintained by the child's parent/guardian and indicates that the required number of doses of vaccine have been received.

Signature of Health Care Provider () Phone _____ Date _____

*See the reverse side