



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

IMMUNIZATION WAIVER FORM

INSTRUCTIONS TO PARENTS OR GUARDIANS:

Sections 9208 and 9211 of the Michigan Public Health Code require that a parent, guardian, or person in *loco parentis* applying to have a child registered for the first time in a Michigan school and/or in 7th grade, or in a program of group residence, care, or camping in this state shall present to officials at the time of registration or no later than the first day of school or program enrollment, a certificate of immunization verifying that the child has been vaccinated against diphtheria, tetanus, pertussis, measles, mumps, rubella, polio, hepatitis B, and varicella (chickenpox). Pneumococcal conjugate and *Haemophilus influenzae* type b vaccines are also required for preschool-aged children. Meningococcal vaccine and Tdap are also required for children who are 11 years of age or older upon entry into 7th grade or higher and newly enrolled in the district.

A parent or guardian wishing to exempt his or her child from a particular vaccination must provide a written statement indicating the religious or philosophical objections to the vaccination(s). This waiver must be certified by the local health department. A child who has been exempted from a vaccination is considered susceptible to the disease or diseases for which the vaccination offers protection. **The child may be subject to exclusion from the school or program, if the local and/or state public health authority advises exclusion as a disease control measure.**

By signing this waiver, I acknowledge that I have been informed that I may be placing my child and others at risk of serious illness should he or she contract a disease that could have been prevented through proper vaccination.

ALL INFORMATION MUST BE FILLED IN BELOW:

I object to having my child, _____, born _____, immunized with the vaccines I have checked below: (First & Last Name) (Birth Date)

- | | |
|--|---|
| <input type="checkbox"/> DTaP, DT, Td, Tdap (Diphtheria, Tetanus, Pertussis) | <input type="checkbox"/> <i>Haemophilus influenzae</i> type b |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Pneumococcal Conjugate |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Varicella (chickenpox) |
| <input type="checkbox"/> MMR (Measles, Mumps, Rubella) | <input type="checkbox"/> Meningococcal Conjugate |

Reason: _____

Parent(s)/Guardian(s) Name: _____

Address: _____ Telephone: _____

Preschool Program or Licensed Day Care Center OR School Name (Required) _____

Parent or Guardian's Signature _____

Date Signed _____

Local Health Department Signature _____

Stamp _____

Date Signed _____

File in the child's permanent record and send a copy to your local health department.

*Condition of acceptance is based on local health department policies.

DCH-0716

AUTHORITY: P. A. 368 OF 1978, Part 92

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