

By state law (A.R.S. 15-873), we are required to have either a record of immunization or this exemption statement. If you wish your child to be exempt from the immunization requirements, submit the online form, or print it out and mail it to:

Enrollment

Sequoia Choice - AZ Distance Learning

P.O. BOX 1405

Mesa, Az. 85211-1405

Please indicate below the type of exemption requested and complete all required information. In the event of outbreak of a vaccine preventable disease for which you cannot provide proof of immunity of your child, your child will not be allowed to be on campus until the risk period ends.

**MEDICAL REASONS**

If immunization would be a health risk to the child because of pre-existing medical conditions, you must sign the statement below along with your physician's signature. The exemption may be for one or more vaccines, and may be either permanent or temporary. If the condition is temporary, the date of its end must be given, at which time the child must receive any necessary vaccine doses.

**PERSONAL BELIEFS**

If immunizations are against your personal or religious beliefs, you must sign the statement below to exempt your child from the requirements.

**LABORATORY EVIDENCE**

If your child has previously had a vaccine preventable disease, immunization against that disease is not required if laboratory evidence of immunity signed by a physician can be provided. Copies of lab results must accompany this request.

I hereby request an exemption from the immunization requirements for the child listed below and understand the risks and possible outcomes of this decision.

Child's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Type of Exemption Requested:

(MARK ONE)

\_\_\_\_ Medical: Choose one of the following:

\_\_\_\_ Permanent

\_\_\_\_ Temporary Until: \_\_\_\_\_(M/D/Y)

\_\_\_\_ Personal Beliefs

\_\_\_\_ Laboratory Evidence

For the Following Vaccines:

(MARK ALL THAT APPLY)

- |                                     |   |
|-------------------------------------|---|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Mumps                  |
| <input type="checkbox"/> Tetanus    | <input type="checkbox"/> Rubella                |
| <input type="checkbox"/> Pertussis  | <input type="checkbox"/> Polio                  |
| <input type="checkbox"/> Measles    | <input type="checkbox"/> Hæmophilus Influenzæ B |

Required Signatures: Parent or guardian must sign all requests, and physician must also sign any request for medical or laboratory evidence exemptions.

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Physician or Health Agency representative

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date