Iowa Department of Public Health
Certificate of Immunization Exemption
Religious Exemption

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

A religious exemption may be granted to an applicant only if immunization conflicts with a genuine and sincere religious belief. A Certificate of Immunization Exemption for religious reasons shall be signed by the applicant or, if the applicant is a minor, by the parent or guardian or legally authorized representative. By signing this certificate you are attesting that the immunization conflicts with a genuine and sincere religious belief and that the belief is in fact religious, and not based merely on philosophical, scientific, moral, personal, or medical opposition to immunizations. The Certificate of Immunization Exemption for religious reasons is valid only when notarized. A child granted a religious exemption may be excluded from child care or school during a disease outbreak. The length of time a child is excluded from child care or school will vary depending on the type of disease and the circumstances surrounding the outbreak, and could range from several days to over a month.

By signing this form, I acknowledge the Iowa Department of Public Health has published information regarding immunizations on the Department's website, including:

- Information that failure to complete the required immunizations increases the risk to my child and others of contracting, carrying, and spreading a vaccine-preventable disease; and
- Information that there are children with special health needs attending schools and child care who are unable to be vaccinated or who are at a heightened risk of contracting a vaccine-preventable disease and for whom such a disease could be life-threatening.

Signature: _____ Date: _____
Applicant, Parent or Guardian

State of _____ County of _____

This instrument was acknowledged before me on _____ Stamp or Seal
Date

by _____
Name(s) of Person(s)

Signature of Notary Public: _____

Title (or Rank for Military Personnel): _____

My commission expires: _____

June 2015

Iowa Department of Public Health
Certificate of Immunization Exemption

Medical Exemption

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

The above named applicant qualifies for a medical exemption to immunization for the following reason (select one):

☐ In the opinion of a physician, nurse practitioner, or physician assistant the following required immunization(s) would be injurious to the health and well-being of the applicant or any member of the applicant's family or household (contraindication due to contact with family or household member applies only to MMR and Varicella vaccine). Check only those immunizations which are medically contraindicated:

- ☐ Hep B (Hepatitis B)
- ☐ DTaP (Diphtheria, Tetanus, Pertussis)
- ☐ IPV (Polio)
- ☐ Hib (*haemophilus influenza* type b)
- ☐ PCV (Pneumococcal)
- ☐ MMR (Measles/Rubella)
- ☐ Varicella (Chickenpox)
- ☐ Tdap (Tetanus, Diphtheria, Pertussis)

If, in the opinion of the physician, nurse practitioner, or physician assistant issuing the medical exemption, the exemption should be terminated or reviewed at a future date, an expiration date shall be recorded on the Certificate of Immunization Exemption.

☐ Administration of the following required vaccine(s) would violate minimum interval spacing of at least 28 days from a dose of a previously received live vaccine. In this circumstance, the exemption shall apply only to an applicant who has not received prior doses of exempted vaccine. An expiration date, not to exceed 60 days, shall be recorded on the certificate. Check only the immunizations which are medically contraindicated:

- ☐ MMR (Measles/Rubella)
- ☐ Varicella (Chickenpox)

Certificate Expiration Date: _____

A child granted a medical exemption may be excluded from child care or school during a disease outbreak. The length of time a child is excluded from child care or school will vary depending on the type of disease and the circumstances surrounding the outbreak, and could range from several days to over a month. A Certificate of Immunization Exemption for medical reasons is valid only when signed by an Iowa licensed physician, nurse practitioner, or physician assistant.

By signing this certificate, I certify the immunizations specified on this certificate would be injurious to the health of the applicant, to a member of the applicant's family or household or the required vaccine would violate the minimum interval spacing.

Name (Print): _____
Physician (MD or DO), Physician Assistant, or Nurse Practitioner

Iowa License Number: _____
Physician (MD or DO), Physician Assistant, or Nurse Practitioner

Signature: _____ Date: _____
Physician (MD or DO), Physician Assistant, or Nurse Practitioner

Iowa Department of Public Health
Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian _____ Address: _____ Phone: _____

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: _____ Date: _____

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap			
Polio IPV/OPV			
Measles, Mumps, Rubella MMR			
Haemophilus influenzae **type b** Hib			
Hepatitis B			

	Vaccine	Date Given	Doctor / Clinic / Source
Varicella Chicken Pox *If applicant has a history of natural disease write "Immune to Varicella"*			
Pneumococcal PCV/PPV			
Meningococcal MCV4/MPSV4			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			