| | mmunization Form Name | | Birthdate | | |
|---|--|---------------|--------------------|--------------|---------------|
| has received to date. Specify the month, day, and year of each dose | Immunizations required for child care, early child | | | | |
| such as 01/01/2010. | Birth to 6 months | 12 -24 months | At Kindergarten | At 7th grade | At 12th grade |
| Vaccine | | | | | |
| Hepatitis B | | | | | |
| Diphtheria, Tetanus, Pertussis (DTaP, DT, Td) | | | | | |
| Haemophilus influenzae type b (Hib) | | | | | |
| Pneumococcal (PCV) | | | | | |
| Polio | | | | | |
| Measles, Mumps, Rubella (MMR) | | | | | |
| Chickenpox (varicella) | | | | | |
| Hepatitis A | | | | | |
| Tetanus, Diphtheria, Pertussis (Tdap) | | | | | |
| Meningococcal (MCV4) | | | | | |

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

- 1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
 - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
 - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
- 2. Sign or get the signatures needed for the back of this form.
 - Document medical and/or non-medical exemptions in section 1.
 - Verify history of chickenpox (varicella) disease in section 2.
 - Provide consent to share immunization information (optional) in section 3.



Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name_

1. Document a medical and/or non-medical exemption (A and/or B).

Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

| Vaccine | Medical Exemption | Non-Medical Exemption |
|------------------------------------|----------------------|--------------------------|
| Diphtheria, Tetanus, and Pertussis | | |
| Polio | | |
| Measles, Mumps, Rubella | | |
| Haemophilus influenzae type b | | |
| Chickenpox (varicella) | | |
| Pneumococcal | | |
| Hepatitis A | | |
| Hepatitis B | | |
| Meningococcal | | |

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature:

(of parent or guardian in presence of notary)

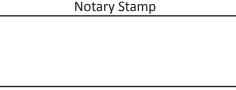
Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me

on _____ (date)

by _ (name of parent or guardian)

Notary Signature:



Date:

| Signature: Date: | | | |
|--|--|--|--|
| (of health care practitioner*) | | | |
| 2. History of chickenpox (varicella) disease. This child had chickenpox month and year My signature below means that I confirm that this child does not need chickenpox vaccine because: I am a health care practitioner and this child was previously diagneed with chickenpox or the parent provided a description that indicate child had chickenpox in the past. | to share your child's immunization record with Minnesota's immunization information system. Giving your permission will: Provide easier access for you and your school to check immunization records, such as at school entry each year. Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak. | | |
| I am the parent or guardian and this child had chickenpox on or be September 1, 2010. | Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives. | | |
| Signature: | I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system: | | |
| *Health care practitioner is defined as a licensed physician, nurse practitione physician assistant. Minnesota Department of Health - Immunization Program (2019) | er, or Signature: Date: | | |

STATE OF MINNESOTA, COUNTY OF