ARIZONA DEPARTMENT OF HEALTH SERVICES

Comments:

Personal Beliefs Exemption Form

Kindergarten – 12th Grade Only

Arizona Department of Health Services (ADHS) strongly supports immunization as one of the easiest and most effective tools in preventing diseases that can cause serious illness and even death. ADHS also respects the rights of parents to decide whether or not to vaccinate their child.

By state law, (A.R.S. §15-873) a child will not be allowed to attend school until either proof of immunization or a completed exemption form is submitted to the school. The information below is provided to ensure that parents are informed about the risks of not vaccinating.

Place an "X" in the box to the left of the disease(s) listed to exempt your child from the vaccine. Initial and date the box on the right.

☐	**Diphtheria (DTaP, Tdap, Td):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing diphtheria if exposed to this disease. Serious symptoms and effects of this disease include: heart failure, paralysis (can't move parts of the body), breathing problems, coma, and death.	Initials_____ Date_____
☐	**Tetanus (DTaP, Tdap, Td):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing tetanus if exposed to this disease. Serious symptoms and effects of this disease include: "locking" of the jaw, difficulty in swallowing and breathing, seizures (jerking and staring), painful tightening of muscles in the head and neck, and death.	Initials_____ Date_____
☐	**Pertussis (Whooping Cough) (DTaP, Tdap):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing pertussis (whooping cough) if exposed to this disease. Serious symptoms and effects of this disease include: severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures (jerking and staring), brain damage, and death.	Initials_____ Date_____
☐	**Polio (IPV):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing polio if exposed to this disease. Serious symptoms and effects of this disease include: paralysis (can't move parts of the body), meningitis (infection of the brain and spinal cord covering), permanent disability, and death.	Initials_____ Date_____
☐	**Measles, Mumps, Rubella (MMR):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing measles, mumps, and/or rubella if exposed to these diseases. Serious symptoms and effects of measles include: pneumonia, seizures (jerking and staring), brain damage, and death. Serious symptoms and effects of mumps include: meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, sterility, deafness, and death. Serious symptoms and effects of rubella include: rash, arthritis, and muscle or joint pain. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, and brain damage.	Initials_____ Date_____
☐	**Hepatitis B:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing hepatitis B if exposed to this disease. Serious symptoms and effects of this disease include: jaundice (yellow skin or eyes), life-long liver problems, such as scarring and liver cancer, and death.	Initials_____ Date_____
☐	**Varicella (Chickenpox):** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing varicella (chickenpox) if exposed to this disease. Serious symptoms and effects of this disease include: severe skin infections, pneumonia, brain damage, and death.	Initials_____ Date_____
☐	**Meningococcal:** I have been informed that by not receiving this vaccine, my child may be at increased risk of developing meningococcal disease. Serious symptoms and effects of this disease include: brain damage, sepsis (systemic infection) permanent scarring or loss of limbs, and death.	Initials_____ Date_____

Due to my personal beliefs, I request an exemption for my child from the required vaccine doses selected above. I am aware that if I change my mind in the future, I can rescind this exemption and obtain immunizations for my child.

Initials_____

- I am aware that additional information about vaccine preventable diseases, vaccines and reduced or no cost vaccination services are available from my local county health department and Arizona Department of Health Services (www.azdhs.gov/phs/immunization/).
- I am aware that in the event the state or county health department declares an outbreak of a vaccine-preventable disease for which I cannot provide proof of immunity for my child, he or she may not be allowed to attend school until the risk period ends, which may be 3 weeks or longer.

Child's Name _____ Date of Birth (month/day/year)_____

Parent/Guardian Signature_____ Date (month/day/year)_____

Vaccination Personal Belief Exemption Form

Pursuant to 'Arizona Revised Statute' Section 15-873 A.1.

This form confirms that I, _____as the parent of _____ have carefully reviewed the risks and benefits of the immunization products listed for school attendance in Arizona, including the clinical trials relied upon to license these products, and the potential risks and benefits of non-immunization, including information regarding same published by the Center for Disease Control & Prevention, the Food & Drug Administration, and the Arizona Department of Health Services, and based upon same cannot consent to the administration of these products for my child(ren).

Hence, pursuant to Arizona Revised statute Section 15-873 A. 1, these children shall be exempt from all vaccinations, to attend school in Arizona and shall be permitted to attend school except in the case of a disease outbreak in the school, pursuant to Arizona Revised Statute Section 15-873 C.

This statement is to be placed in my children's file in school and may only be shown to the school administrator and/or designated operator of the school records, and consent is hereby expressly withheld from sharing a copy of this statement or its content with any other person or entity, including any organ of government.

Signature of Parent(s)/Guardian(s) Date

_____ _____

Address

_____

Phone #

_____