



# CERTIFICATE OF EXEMPTION FROM SCHOOL/DAYCARE IMMUNIZATION REQUIREMENTS

Please Print Clearly, Complete all Fields, Use CAPITAL LETTERS ONLY

### Child's Information

First Name  Last Name   
 Street address or P.O. Box   
 City  State  Zip Code   
 Phone  -   Child's Grade   
 School Name   
 School Address   
 School City  School State  School Zip Code   
 Child's Date of Birth  m m d d y y y y

### Please check appropriate boxes

<b>Sex</b>	<b>Ethnicity</b>	<b>Race</b>
<input type="radio"/> Male	<input type="radio"/> Hispanic	<input type="radio"/> Native American
<input type="radio"/> Female	<input type="radio"/> Non-Hispanic	<input type="radio"/> Black
		<input type="radio"/> Other
		<input type="radio"/> Asian
		<input type="radio"/> White

*Mail or bring original to:*  
**NM Immunization Program**  
**1190 St. Francis/ Runnels S-1250**  
**PO Box 26110**  
**Santa Fe, NM 87502-6110**

### I object to my child receiving the following vaccines:

<input type="radio"/> Tetanus	<input type="radio"/> Hib - Haemophilus Influenza type B	<input type="radio"/> Hepatitis A
<input type="radio"/> Diphtheria	<input type="radio"/> Measles	<input type="radio"/> Hepatitis B
<input type="radio"/> Pertussis	<input type="radio"/> Mumps	<input type="radio"/> Varicella (Chicken Pox)
	<input type="radio"/> Rubella	<input type="radio"/> Polio

### Directions:

Please complete this form. Then in the presence of a Notary Public, please sign and date the certificate and have it notarized. IT IS THE PARENT/GUARDIAN'S RESPONSIBILITY TO ENSURE AN APPROVED COPY OF THIS EXEMPTION CERTIFICATE IS FILED WITH THE CHILD'S SCHOOL.

In accordance with 7.5.3.8B NMAC, I hereby certify that my religious beliefs, held either individually or jointly by others, do not permit the administration of vaccine or other immunizing agents and I therefore request that my child as named above be exempted from the school immunization requirements of NMSA 1978 Section 24-5-2.

I UNDERSTAND THIS REQUEST IS SUBJECT TO THE APPROVAL OF THE NEW MEXICO DEPARTMENT OF HEALTH. I HAVE READ THE 'COMPULSORY IMMUNIZATION REGULATIONS' AND UNDERSTAND THE RISK OF NON-IMMUNIZATION FOR MY CHILD. I UNDERSTAND THAT THIS CERTIFICATE, IF APPROVED, IS VALID FOR A PERIOD NOT TO EXCEED NINE MONTHS AND WILL EXPIRE THEREAFTER. IF I WISH TO REQUEST ANOTHER EXEMPTION AFTER THE NINE MONTH PERIOD, I MUST COMPLETE ANOTHER CERTIFICATE OF EXEMPTION AND SEEK APPROVAL.

I ALSO UNDERSTAND THAT WHERE ANY CASE OF COMMUNICABLE DISEASE OCCURS OR IS LIKELY TO OCCUR IN MY CHILD'S SCHOOL, THE DEPARTMENT OF HEALTH MAY REQUIRE THE EXCLUSION OF INFECTED PERSONS AND NON-IMMUNIZED PERSONS (7.4.3.9 NMAC - Rp, 7 NMAC 4.3.9, 8/15/2003).

I swear that all the foregoing statements are true to the best of my information, knowledge and belief.

Parent/guardian's name (print clearly) \_\_\_\_\_

Parent/guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.



\_\_\_\_\_  
 Notary's Signature and Seal My Commission expires: \_\_\_\_\_

DOH Use Only:  APPROVED  DISAPPROVED

Date approved  m m d d y y y y