

CERTIFICATE OF EXEMPTION FROM SCHOOL/DAYCARE IMMUNIZATION REQUIREMENTS



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

Child's Information

First Name School Name
 Last Name School Address
 Address or P.O. Box School City
 City School State School Zip Code
 State Zip Code Child's Grade
 Phone Child's Date of Birth

Sex
 Male Female
Ethnicity
 Hispanic Non-Hispanic
Race
 Native American Black Other
 Asian White

I object to my child receiving the following:

Tetanus Hib - Haemophilus Influenza type B Hepatitis A
 Diphtheria Measles Hepatitis B
 Pertussis Mumps Varicella (Chicken Pox)
 Pneumococcal Rubella Polio

I request that the 9 month period this exemption form is valid for begin on

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

Directions

Please complete this form. Check the box that corresponds to your request for exemption. Then in the presence of a Notary Public, please sign and date this 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.

I request exemption from immunization requirements in accordance with:

- NMAC 7.5.3.8 A.1, and I am attaching an affidavit or certificate from a duly licensed physician attesting that any of the required immunizations would seriously endanger the life or health of my child.
- NMAC 7.5.3.8 A.2, because I am presenting an affidavit or written affirmation from an officer of my denomination stating we are bona fide members of a recognized religious denomination which requires reliance on prayer or spiritual means alone for healing.
- NMAC 7.5.3.8, and I hereby certify that my religious beliefs, held either individually or jointly with others, do not permit the administration of vaccine or other immunizing agents.

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: _____

Notary Seal



NOTARY

Subscribed and sworn before me this _____ day of _____, 20____.
 _____ My Commission expires: _____

Notary's Signature

DOH Use Only:

DISAPPROVED

APPROVED BEGINS ON

Date m m d d y y y y

Revised July 8, 2013

 Authorized Signature

EXPIRES ON

Date m m d d y y y y