



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

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

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