

**CERTIFICATE OF EXEMPTION**  
**FROM SCHOOL/DAYCARE IMMUNIZATION REQUIREMENTS**



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

**Child's Information**

**School Information**

First Name	<input type="text"/>	School Name	<input type="text"/>
Last Name	<input type="text"/>	School District	<input type="text"/>
Mailing Address	<input type="text"/>	School Address	<input type="text"/>
City	<input type="text"/>	School City	<input type="text"/>
State	Zip Code <input type="text"/>	School State	School Zip Code <input type="text"/>
Phone	Child's Date of Birth <input type="text"/>	Child's Grade	<input type="text"/>

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**Sex**      **Ethnicity**      **Race**

Male    Female  
  Hispanic    Non-Hispanic  
  Native American    Asian  
  Black    White    Other

**I object to my child receiving the following:**

- |                                    |  |   |
|------------------------------------|--|---|
| <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"/> Pneumococcal | <input type="radio"/> Rubella                            | <input type="radio"/> Polio                   |
|                                    |  | <input type="radio"/> Meningococcal           |

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 and include the required information. 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, and I am attaching 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 A.3, and I hereby certify through the written affirmation below, or attached affidavit, that my religious beliefs, held either individually or jointly with others, do not permit the administration of vaccine or other immunizing agents.

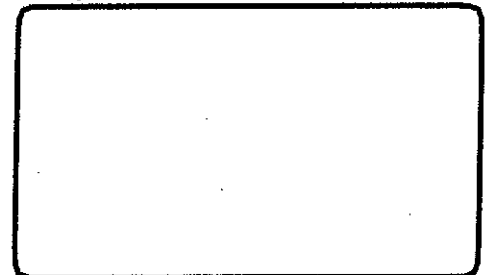
I UNDERSTAND THIS REQUEST IS SUBJECT TO THE APPROVAL OF THE NEW MEXICO DEPARTMENT OF HEALTH. I HAVE READ THE 'COMPULSORY IMMUNIZATION REGULATIONS' AND UNDERSTAND THE RISK OF NON-IMMUNIZATION FOR MY CHILD. I UNDERSTAND THAT THIS CERTIFICATE, IF APPROVED, IS VALID FOR A PERIOD NOT TO EXCEED NINE MONTHS 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:

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