IOWA Health and Human Services

Provisional Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

The applicant shall submit this certificate to the admitting official of the school or child care center. A copy of this certificate should be provided to the applicant, parent or guardian.

This applicant qualifies for a provisional enrollment for one of the following reasons (select one):

- ☐ Has received at least one dose of each of the required vaccines but has not completed all the required immunizations or;
- ☐ Is a transfer student from another school system. A transfer student is an applicant seeking enrollment from one U.S. domestic elementary or secondary school to another.

The amount of time allowed for provisional enrollment shall be as rapidly as medically feasible but shall not exceed 60 calendar days. The period of provisional enrollment shall begin on the date the certificate is signed. To be valid, the certificate shall be completed in its entirety including an expiration date and list of remaining vaccines required to qualify for a Certificate of Immunization.

Certificate Expiration Date: _____

Remaining Vaccine(s) Required: _____

_____

I certify that the above named applicant is hereby issued a Provisional Certificate of Immunization and I have informed the applicant, parent or guardian of the provisional enrollment requirements.

Name (Print): _____
Physician (MD or DO), Physician Assistant, Nurse, or Certified Medical Assistant

Signature: _____
Physician (MD or DO), Physician Assistant, Nurse, or Certified Medical Assistant

Date: _____

Record of Immunization			
Vaccine	**Vaccine Type**	**Date Given**	**Source**
Diphtheria, Tetanus, Pertussis DTaP/DTP/ DT/ Td/Tdap			
Polio IPV/OPV			
Measles, Rubella MMR			
Haemophilus influenzae type b Hib			
Hepatitis B Hep B			
Varicella* Chickenpox			
Pneumococcal PCV			
Meningococcal MenACWY			

* If patient has a history of natural disease, write “Immune to Varicella”.

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Medical Certificate of Immunization Exemption

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

The above named applicant qualifies for a medical exemption to immunization for the following reason (select one):

☐ In the opinion of a physician, nurse practitioner, or physician assistant the following required immunization(s) would be injurious to the health and well-being of the applicant or any member of the applicant's family or household (contraindication due to contact with family or household member applies only to MMR and Varicella vaccine). Select only those vaccines which are medically contraindicated:

- ☐ Hepatitis B (Hep B)
- ☐ *haemophilus influenzae* type b (Hib)
- ☐ Varicella (Chickenpox)
- ☐ Diphtheria, Tetanus, Pertussis (DTaP)
- ☐ Pneumococcal (PCV)
- ☐ Tetanus, Diphtheria, Pertussis (Tdap)
- ☐ Polio (IPV)
- ☐ Measles, Rubella (MMR)
- ☐ Meningococcal (MenACWY)

If, in the opinion of the physician, nurse practitioner, or physician assistant issuing the medical exemption, the exemption should be terminated or reviewed at a future date, an expiration date shall be recorded on the Certificate of Immunization Exemption.

☐ Administration of the following required vaccine(s) would violate minimum interval spacing of at least 28 days from a dose of a previously received live vaccine. In this circumstance, the exemption shall apply only to an applicant who has not received prior doses of exempted vaccine. An expiration date, not to exceed 60 days, shall be recorded on the certificate. Check only the immunizations which are medically contraindicated:

- ☐ Measles, Rubella (MMR)
- ☐ Varicella (Chickenpox)

Certificate Expiration Date: _____

A child granted a medical exemption may be excluded from child care or school during a disease outbreak. The length of time a child is excluded from child care or school will vary depending on the type of disease and the circumstances surrounding the outbreak, and could range from several days to over a month. A Certificate of Immunization Exemption for medical reasons is valid only when signed by an Iowa licensed physician, nurse practitioner, or physician assistant.

The Medical Exemption shall be submitted by the applicant or, if the applicant is a minor, by the applicant's parent or guardian to the admitting official of the school or licensed child care center in which the applicant wishes to enroll.

By signing this certificate, I certify the immunizations specified on this certificate would be injurious to the health of the applicant, to a member of the applicant's family or household, or the required vaccine would violate the minimum interval spacing.

Name (Print): _____ Iowa Medical License Number: _____
Physician (MD or DO), Physician Assistant, or Nurse Practitioner

Signature: _____ Date: _____
Physician (MD or DO), Physician Assistant, or Nurse Practitioner

IOWA | Health and Human Services

Religious Certificate of Immunization Exemption

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

A religious exemption may be granted to an applicant only if immunization conflicts with a genuine and sincere religious belief. A Certificate of Immunization Exemption for religious reasons shall be signed by the applicant or, if the applicant is a minor, by the parent or guardian or legally authorized representative. By signing this certificate, you are attesting that the immunization conflicts with a genuine and sincere religious belief and that the belief is in fact religious, and not based merely on philosophical, scientific, moral, personal, or medical opposition to immunizations.

A child granted a religious exemption may be excluded from child care or school during a disease outbreak. The length of time a child is excluded from child care or school will vary depending on the type of disease and the circumstances surrounding the outbreak, and could range from several days to over a month.

By signing this form, I acknowledge the Iowa Department of Health and Human Services has published information regarding immunizations on the Department's website, including:

- Information that failure to complete the required immunizations increases the risk to my child and others of contracting, carrying, and spreading a vaccine-preventable disease; and
- Information that there are children with special health needs attending schools and child care who are unable to be vaccinated or who are at a heightened risk of contracting a vaccine-preventable disease and for whom such a disease could be life-threatening.

The Religious Exemption shall be submitted by the applicant or, if the applicant is a minor, by the applicant's parent or guardian to the admitting official of the school or licensed child care center in which the applicant wishes to enroll.

Name (Print): _____
Applicant, Parent or Guardian

Signature: _____ Date: _____
Applicant, Parent or Guardian