



W A L D O R F
C O L L E G E

Lost or Destroyed Record: (Must be reviewed and approved by a physician or local health department.)

I hereby certify that the immunization records of this child have been lost, destroyed, or are unobtainable.

Signed _____ Date _____
(Parent or Guardian)

**** COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE. ****

I understand that not only am I putting my self at risk but also other students I come in contact with.

Medical Contraindication:

The physical condition of the above pupil is such that immunization at this time would constitute a serious threat to his / her health.

This is a permanent condition _____ temporary condition _____ until _____
MO/Day / Yr

Check appropriate line above; indicate vaccine(s) and reasons below.

Signed _____ Date _____
(Parent or Guardian)

Religious Objection:

I am the parent/ guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunization being given to my child.

Signed _____ Date _____
(Parent or Guardian)