IMMUNIZATION VERIFICATION/WAIVER FORM

HUMAN RESOURCES BRANCH

(SCCOE DOES NOT COVER THE COST OF IMMUNIZATIONS)

Please either submit proof of vaccinations (yellow card, pharmacy receipts, etc.) or complete this form with your healthcare professional. You may also use this form to waive receiving the influenza vaccination.

All individuals who work in one of our Early Learning Centers (Head Start, State Preschool or Educare) are required to provide evidence of certain immunizations. This is a requirement by law to maintain or gain employment with any agency that operates a licensed childcare center.

Name (please print clearly): __________________________________________________________

Status:  ☐ Employee  ☐ Substitute  ☐ Volunteer  ☐ Contractor  ☐ Other ___________

Influenza (must be given or declined annually between August 1 and December 1):

☐ Vaccine __________________________   Date: ________________

☐ There is a medical reason not to vaccinate the individual against influenza.

☐ The individual has declined influenza vaccine per statement/signature as follows:

  Statement: ________________________________________________________________

  Employee Signature (if declining): ______________________________Date: ___________

Pertussis:

☐ Vaccine __________________________   Date: ________________

☐ There is evidence the individual is already immune against pertussis.

☐ There is a medical reason not to vaccinate the individual against pertussis.

Measles:

☐ Vaccine __________________________   Date: ________________

☐ There is evidence the individual is already immune against measles.

☐ There is a medical reason not to vaccinate the individual against measles.

_____________________________________ ______________________
Authorized Medical Provider Signature  Date

_____________________________________  _________________   (___)____________
Printed Name of Authorized Medical Provider  License Number   Phone Number

☐ Please check this box if a physician statement or vaccination record has been attached.