

District of Columbia Department of Health

Annual Religious Immunization Exemption Certificate

STUDENTS in Public, Charter, Private, Parochial, Preschool, AND CHILDREN in Child Care Facilities - DC Health recognizes the importance of vaccinations for preventing disease and reducing the dangers that can come with being exposed to certain diseases. DC Law 3-20 requires parents opposed to vaccinations due to religious beliefs to object in good faith and in writing that immunization(s) would violate a sincerely held religious belief and provide it to DC Health.

This certificate may be used to request an exemption from required immunizations based on sincerely held religious beliefs. This is a religious immunization exemption. This certificate should be completed annually by the parent/guardian of a student or child, or by a student greater than age 18, and will remain valid for one school year (July 1-June 30). A separate exemption certificate is necessary for each student or child.

Instructions for completing this form:

Section 1: Enter information of child or student and requestor.

Section 2: Check, Initial, and date vaccines for exemption

Section 3: Print name, sign, and date.

Submission: This certificate or another writing must be submitted directly to DC Health at doh.immunization@dc.gov OR mailed by USPS or hand-delivered to DC Health, 2201 Shannon Place SE, Washington, DC 20020, 5th Floor.

Last Name:		First Name:		Date of Birth:
Home Address:	Apt:	City:	State:	Zip code:
School:				
Parent/Guardian/Requestor (P/G/R) Name:		P/G/R Phone:		Email address:
Name and Address of Health Care Provider:		Address		Phone

Section 2: Immunization Exemptions: Place an "X" in a box or boxes to the left of each disease, listed below, for which you do not allow your child or student to receive the vaccine due to sincerely held religious beliefs. Initial and date the box on the right. (To be completed by parent/guardian, or student if the student is age 18 years or older).

I understand by not receiving this vaccine --- my child or student:

<input type="checkbox"/>	Hepatitis B: Is at increased risk of developing hepatitis B if exposed to this disease. Serious symptoms and effects of this disease include jaundice (yellow skin and eyes), life-long liver problems, such as scarring and liver cancer, and death.	Initials _____ Date _____
<input type="checkbox"/>	Diphtheria (DTaP, DT, Tdap, Td): Is at increased risk of developing diphtheria if exposed to this disease. Serious symptoms and effects of this disease include heart failure, paralysis (can't move parts of the body), breathing problems, coma, and death.	Initials _____ Date _____
<input type="checkbox"/>	Tetanus (DTaP, DT, Tdap, Td): Is at increased risk of developing tetanus if exposed to this disease. Serious symptoms and effects of this disease include: "locking" of the jaw, difficulty in swallowing and breathing, seizures (jerking and staring), painful tightening of muscles in the head and neck, or death.	Initials _____ Date _____
<input type="checkbox"/>	Pertussis (Whooping Cough) (DTaP, Tdap): Is at increased risk of developing pertussis (whooping cough) if exposed to this disease. Serious symptoms and effects of this disease include severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures (jerking and staring), brain damage, and death.	Initials _____ Date _____
<input type="checkbox"/>	Haemophilus influenzae type b (Hib): Is at increased risk of developing Hib if exposed to this disease. Serious symptoms and effects of this disease include meningitis (infection of the brain and spinal cord covering), pneumonia, severe swelling in the throat that makes it hard to breathe, infections of the blood, joints, bones, and covering of the heart, and death.	Initials _____ Date _____
<input type="checkbox"/>	Pneumococcal: Is at increased risk if exposed to this disease. Serious symptoms and effects of this disease include chest pain with rapid breathing or difficulty breathing, a high fever, shaking, chills, excessive sweating, fatigue, confusion, and a cough with phlegm that persists or worsens, pneumonia, brain damage, and death.	Initials _____ Date _____
<input type="checkbox"/>	Polio: Is at increased risk of developing polio if exposed to this disease. Serious symptoms and effects of this disease include paralysis (can't move parts of the body), meningitis (infection of the brain and spinal cord covering), permanent disability, or death./	Initials _____ Date _____
<input type="checkbox"/>	Measles, Mumps, Rubella (MMR): Is at increased risk of developing measles, mumps, and/or rubella if exposed to this disease. Serious symptoms and effects of measles include pneumonia, seizures (jerking and staring), brain damage, or death. Serious symptoms and effects of mumps include meningitis (infection of the brain and spinal cord covering), swelling of the testicles or ovaries, sterility, deafness, or death. Serious symptoms and effects of rubella include rash, arthritis, and muscle or joint pain. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, or learning disability.	Initials _____ Date _____
<input type="checkbox"/>	Varicella (Chickenpox): Is at increased risk of developing varicella (chickenpox) if exposed to this disease. Serious symptoms and effects of this disease include severe skin infections, pneumonia, brain damage, or death.	Initials _____ Date _____
<input type="checkbox"/>	Hepatitis A: Is at increased risk for developing hepatitis A if exposed to this disease. Serious symptoms and effects of this disease include jaundice (yellow skin or eyes), "flu-like" illness, hospitalization, or death.	Initials _____ Date _____

<input type="checkbox"/>	Meningococcal: Is at increased risk of developing meningococcal disease if exposed to this disease. Serious symptoms and effects of this disease include severe headache, stiff neck, confusion, seizures (jerking and staring), high fever, nausea and vomiting, sensitivity of eyes to light, hearing loss, pneumonia, brain damage, or death.	Initials _____ Date _____
<input type="checkbox"/>	Human Papillomavirus (HPV): Is at increased risk of developing human papillomavirus infection if exposed to this disease. Serious symptoms and effects of this disease include genital warts, cancer of the cervix, vulva, vagina, penis, or anus, and cancer of the throat.	Initials _____ Date _____

Section 3: Acknowledgement and Signature

Due to my sincerely held religious beliefs, I oppose ☐ my child ☐ myself (if I am a student at least 18 years or older) receiving the required immunizations selected above. I am aware that if I change my mind, I can reverse this objection and obtain the required immunizations for my child or myself at any time.

I understand that if an outbreak of a vaccine-preventable disease should occur, an exempt student will be excluded from school/childcare by the school/childcare administrative head for a period of time as determined by DC Health based on a case-by-case analysis of public health risk. For additional information please go to <https://dchealth.dc.gov/service/immunization>.

Print Name of Parent/Guardian, Student if 18 years or older:

Signature of Parent/Guardian, Student if 18 years or older:

Date: