



# HUBER HEIGHTS CITY SCHOOLS

900.74  
08/29/19

## PARENTAL OBJECTION FORM STUDENT HEALTH IMMUNIZATION

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Parent's/Guardian's Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

In accordance with Section 3313.671 of the Ohio Revised Code of Law, I hereby state that I object to the following immunization of my child: \_\_\_ DPT \_\_\_ Tdap \_\_\_ MMR \_\_\_ Hepatitis B \_\_\_ Polio \_\_\_ Meningococcal \_\_\_ Chickenpox \_\_\_ Hepatitis A \_\_\_ HIB \_\_\_ Other.

I base this objection upon the following good cause:

- \_\_\_\_\_ Religious reasons
- \_\_\_\_\_ Medical reasons. (A signed statement from your physician stating the Condition must accompany this form.
- \_\_\_\_\_ Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I realize that by not permitting this immunization, I am taking full responsibility for any negative consequences which may result for my child.

**I also realize that if there is an outbreak of any of the diseases covered by the state-required immunizations, my child may be excluded from school until the Health Department gives permission for my child to return to school.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian