| JDENT NAME (LAST, FIRST, MIDDLE) | | BIRTHDATE MONTH DAY YEAR / / / / | TELEPHONE NUMBER |
|--|--|---|--|
| RENT/GUARDIAN – NAME | | ADDRESS | |
| A. AUTHORIZED HEALTH CA | RE PRACTITION | | IIA - FILL OUT THIS SECTIO |
| I am a (check one): 🔲 M.D./D.O. 🗌 | Nurse Practitioner |] Physician Assistant | Doctor Credentialed School Nurs |
| Provision of information: I have provision of information: I have provide the care and custod benefits and risks of immunization ar which immunization is required in Ca | y of the student, or t id 2) the health risks | the student if an emancipated minor, to the student and to the community | with information regarding 1) the |
| | | Practitioner name, address, tele | phone number: |
| Signature of authorized health care practitio | ner | | |
| | | | |
| Date - within 6 months before entry to child | care or school | | |
| 3. PARENT OR GUARDIAN - | | | |
| . PARENI UR GUARDIAN - | FILL OUT THES | E SECTIONS | |
| | FILL OUT THES | SE SECTIONS | |
| | FILL OUT THES | SE SECTIONS | |
| Check one of the boxes below: Receipt of information: I have re and risks of immunization and 2) the function of the second second | ceived information p ne health risks to the | provided by an authorized health card | ommunity of the communicable |
| Check one of the boxes below: Receipt of information: I have re and risks of immunization and 2) th diseases for which immunization is | ceived information p ne health risks to the required in Californ r of a religion which | provided by an authorized health care e student named above and to the co nia (immunizations listed in Table bel prohibits me from seeking medical a | ommunity of the communicable ow). |
| Check one of the boxes below: Receipt of information: I have re and risks of immunization and 2) th diseases for which immunization is Religious beliefs: I am a member health care practitioners. (Signature) | ceived information p ne health risks to the required in Californ r of a religion which | provided by an authorized health care e student named above and to the co nia (immunizations listed in Table bel prohibits me from seeking medical a ractitioner not required in Part A.) | ommunity of the communicable ow). dvice or treatment from authorized |
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| Check one of the boxes below: Receipt of information: I have re and risks of immunization and 2) th diseases for which immunization is Religious beliefs: I am a member | ceived information p ne health risks to the required in Californ r of a religion which p re of a health care p nave provided the ch on (California Health n is requested : An a vaccine-preventa ild care during an ou 5060). I hereby reque | provided by an authorized health care e student named above and to the co- ia (immunizations listed in Table bel prohibits me from seeking medical a ractitioner not required in Part A.) Date - within 6 m hild care or school with a record of al h and Safety Code §120365). unimmunized student and the studen ble disease. I understand that an un utbreak of, or after exposure to, any co- est exemption of the student named | ommunity of the communicable ow). dvice or treatment from authorized onths before entry to child care or school II immunizations the student has nt's contacts at school and home immunized student may be of these diseases for the protection |
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