Request for Exemption from Immunizations for Reasons of Conscience

Date: _____

In order to expedite your request, please print or type the name and date of birth for each child. If you are submitting this request by fax, please provide your telephone number so that we can contact you if there is a problem with the fax transmission.
Thank You.

I wish to obtain an Exemption from Immunizations for Reasons of Conscience Affidavit Form. Please provide me with an exemption affidavit form for each of my children listed below (*maximum 5 forms per child*):

Name of Parent/Legal Guardian: _____

Mailing address: _____

Apartment Number: _____

City/State/Zip: _____

Telephone Number (*Needed for faxed requests*) _____

_____
Signature of Parent or Legal Guardian

Important note: No requests will be filled at the time of hand-delivery.

First Name	Middle Name	Last Name	Birth date (mm/dd/yyyy)	Number of forms

Please mail, fax, or hand deliver your request to:

Mailing Address:
Department of State Health Services Immunization Unit
(MC 1946) P.O. Box 149347
Austin, TX 78714-9347

Hand Deliver:
Department of State Health Services Immunization Unit (MC 1946) 1100 West 49th Street
Austin, TX 78756

Fax (512) 776-7544

Please provide all information requested to expedite your request. Thank you.