CHILD CARE IMMUNIZATION RECORD WAIVER

Please check the appropriate box below, sign and return this form to the Child Care Branch.

❑ Although my child has not received all the required doses of vaccine for his/her age group, at least the first dose of each vaccine has been received.
   I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **within one year** and to provide the date of each immunization as it is received.

❑ For health reasons my child will not receive the following immunizations and my child’s physician has provided the required signature.

____________________________________________________________________________________________________________________________________________________________________________________________________________

Physician’s Signature ____________________________________________
Physician’s Printed Name __________________________________________

❑ For religious reasons my child will not be immunized.

❑ For personal conviction reasons my child will not be immunized.

Please initial next to the following statements acknowledging you’ve read and agree.

___ To the best of my knowledge this form is completed and accurate. I understand that it is my choice to have my child participate if a communicable disease has been reported at the child care site in which my child attends.

___ I am responsible for any resulting effects this may have on my child.

______________________________________________________________
Signature Parent/Guardian Date Printed Parent/Guardian Printed Name

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