Diocese of Steubenville
Office of Christian Formation and Schools
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MEDICAL and/or RELIGIOUS CONVICTIONS IMMUNIZATION EXCEPTION

Diocesan Form M-2

As per Ohio Revised Code 3313.671, Division (A), Parents/Guardians are required to provide proof of immunizations for a pupil entering a diocesan Catholic elementary or high school (see backside of this form).

Ohio Revised Code 3313.671, Division (B) provides the following exceptions, which are permitted by law, from providing proof of required immunizations.

(1) A pupil who has had natural rubeola, and presents a signed statement from the pupil's parent, guardian, or physician to that effect, is not required to be immunized against rubeola.

(2) A pupil who has had natural mumps, and presents a signed statement from the pupil's parent, guardian, or physician to that effect, is not required to be immunized against mumps.

(3) A pupil who has had natural chicken pox, and presents a signed statement from the pupil's parent, guardian, or physician to that effect, is not required to be immunized against chicken pox.

(4) A pupil who presents a written statement of the pupil's parent or guardian, in which the parent or guardian declines to have the pupil immunized for reasons of conscience, including religious convictions, is not required to be immunized.

(5) A child whose physician certifies in writing that such immunization against any disease is medically contraindicated is not required to be immunized against that disease.

Parents/Guardians who wish to claim an exception from providing proof of required immunizations for their child must complete and submit this form to the school office within 14 days of the first day of attendance.

* * * * *

I, the parent or guardian of the below named child, hereby claim exception to the immunization(s) listed for the following reasons: (Please list the immunizations and the reasons for the exception)

_____

_____

_____

_____

I further understand that during the course of an outbreak of any of the afore-mentioned vaccine-preventable diseases that the child named here is subject to exclusion from school for the duration of the outbreak.

(Over)

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DISPENSATION OF MEDICATION, Form M-3

SECTION A – To be completed by the parent

Student's name/birthdate _____ Name of School/Homeroom Teacher _____

Address _____ Telephone number (For Emergency contact) _____

We (I) the undersigned, who are the parent(s) guardian(s) of the above-mentioned child, request that the health care service, outlined below and prescribed by the physician, be provided to our child. We(I) authorize the school to appoint a qualified, designated person(s) to perform the prescribed treatment as directed by the physician. We (I) agree to notify the school personnel immediately if there is any change in either the child's treatment regimen or the authorizing physician.

Parent's/guardian's signature _____ Date _____ Emergency Phone contact _____

SECTION B – To be completed by the physician

Name of Physician _____ Telephone number _____

Office address _____

Name of the treatment/medication: _____

Specific/special instructions for administration: _____

_____

Student may self-medicate: _____ Yes _____ No

Beginning date: _____ Ending date: _____

Adverse reactions that should be reported to the physician: _____

_____

Special storage instructions: _____

Physician's signature: _____
Date

MEDICATION MUST BE IN THE ORIGINAL CONTAINER IN WHICH IT WAS DISPENSED AND LIMITED TO ONLY THAT AMOUNT WHICH IS NEEDED!!

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SELF-MEDICATION FOR ASTHMA INHALERS AUTHORIZATION FORM M-5

Student's name/birthdate _____ Name of School/Homeroom Teacher _____

Address _____ Telephone number (For Emergency contact) _____

Medication Name: _____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to cease: _____

Adverse reactions that should be reported to the physician: _____

_____

Adverse reactions for unauthorized user: _____

_____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack:

_____

_____

Other special instructions: _____

_____

Physician and Parent/guardian Names, Signatures, and Emergency Phone Numbers:

Physician name: _____ Phone: _____

Signature: _____ Date: _____

Parent/Guardian Name: _____ Phone: (Work) _____

(Home) _____

(Other) _____

Signature: _____ Date: _____

Copies of this completed form must be provided to Principal and the School Nurse