Healthcare Provider's Declaration of
In Process Required School Immunizations for PreK or Pre-School
Students Subject to Religious Exemption Prior to April 28, 2021

This declaration is to be used only for a student who **prior to April 28, 2021** was (1) enrolled in a preschool program or other prekindergarten program and (2) exempt from the Connecticut State immunization requirements based on a statement submitted to the program that such immunization requirements would be contrary to the religious beliefs of the student or the parents or guardian of the student[1].

I hereby declare that the student identified below is my patient and that I have confirmed that the student meets the declaration criteria set forth above by receiving a copy of the student's religious exemption statement from the preschool program or other prekindergarten program dated prior to April 28, 2021.

Based on my clinical judgement, I am submitting this declaration on behalf on my patient to whom I will administer immunizations using an alternative vaccine schedule different than the one specified by the Commissioner of Public Health (*Connecticut Department of Public Health Schedule For In Process Required School Immunizations*) for the reasons specified in Part 2 below.

Name of Primary Care Provider: _____

Please check one (practitioner completing this declaration must be licensed as one of the following):

☐ Physician (M.D. or D.O.) ☐ Physician Assistant ☐ APRN

Connecticut License number: _____

Phone number: _____ Email: _____

Directions:

Part 1. Please complete the demographics section on the patient/student.

Part 2. Write a brief explanation of the clinical reason the student requires the alternative catch up schedule than the one specified by the Commissioner of Public Health.

Part 3. Signature of Provider

Print/attach a copy of the student's most current immunization record and a detailed catch-up schedule of the remaining vaccinations for this child (what vaccines they will receive and when they will receive them).

Part 1. Demographic Patient/Student Information:

First name (in full) _____ Middle initial _____ Last name _____

Date of Birth _____

[1] If the student does not meet these requirements, then the *Healthcare Provider's Certification of In Process Required School Immunizations* should be completed.

Mailing Address _____ City_____

State_____ Zip_____

Parent/Guardian: First Name _____ Last name_____

Primary phone number _____

School name_____

School address _____

City_____

State_____Zip_____

Current Grade student is entering _____

Part 2. Clinical Reason for the Alternative Catch up Schedule (check all that apply)

☐ This patient has a family history of an autoimmune disorder

☐ This patient has a family history of a reaction to a vaccination

☐ This patient has a genetic predisposition to a reaction to a vaccination as determined through genetic testing

☐ This patient has a previous documented reaction that is correlated to a vaccination

☐ Other condition/reaction not listed above (must specify):

_____

_____

_____

_____

Part 3.

Signature:_____ Date: _____

Print Name:_____