Iowa Department of Public Health
Certificate of Immunization Exemption

Medical Exemption

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

The above named applicant qualifies for a medical exemption to immunization for the following reason (select one):

☐ In the opinion of a physician, nurse practitioner, or physician assistant the following required immunization(s) would be injurious to the health and well-being of the applicant or any member of the applicant's family or household (contraindication due to contact with family or household member applies only to MMR and Varicella vaccine). Check only those immunizations which are medically contraindicated:

- ☐ Hep B (Hepatitis B)
- ☐ DTaP (Diphtheria, Tetanus, Pertussis)
- ☐ IPV (Polio)
- ☐ Hib (*haemophilus influenza* type b)
- ☐ PCV (Pneumococcal)
- ☐ MMR (Measles/Rubella)
- ☐ Varicella (Chickenpox)
- ☐ Tdap (Tetanus, Diphtheria, Pertussis)

If, in the opinion of the physician, nurse practitioner, or physician assistant issuing the medical exemption, the exemption should be terminated or reviewed at a future date, an expiration date shall be recorded on the Certificate of Immunization Exemption.

☐ Administration of the following required vaccine(s) would violate minimum interval spacing of at least 28 days from a dose of a previously received live vaccine. In this circumstance, the exemption shall apply only to an applicant who has not received prior doses of exempted vaccine. An expiration date, not to exceed 60 days, shall be recorded on the certificate. Check only the immunizations which are medically contraindicated:

- ☐ MMR (Measles/Rubella)
- ☐ Varicella (Chickenpox)

Certificate Expiration Date: _____

A child granted a medical exemption may be excluded from child care or school during a disease outbreak. The length of time a child is excluded from child care or school will vary depending on the type of disease and the circumstances surrounding the outbreak, and could range from several days to over a month. A Certificate of Immunization Exemption for medical reasons is valid only when signed by an Iowa licensed physician, nurse practitioner, or physician assistant.

By signing this certificate, I certify the immunizations specified on this certificate would be injurious to the health of the applicant, to a member of the applicant's family or household or the required vaccine would violate the minimum interval spacing.

Name (Print): _____
Physician (MD or DO), Physician Assistant, or Nurse Practitioner

Iowa License Number: _____
Physician (MD or DO), Physician Assistant, or Nurse Practitioner

Signature: _____ Date: _____
Physician (MD or DO), Physician Assistant, or Nurse Practitioner

June 2015

Iowa Department of Public Health
Certificate of Immunization Exemption
Religious Exemption

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

A religious exemption may be granted to an applicant only if immunization conflicts with a genuine and sincere religious belief. A Certificate of Immunization Exemption for religious reasons shall be signed by the applicant or, if the applicant is a minor, by the parent or guardian or legally authorized representative. By signing this certificate you are attesting that the immunization conflicts with a genuine and sincere religious belief and that the belief is in fact religious, and not based merely on philosophical, scientific, moral, personal, or medical opposition to immunizations. The Certificate of Immunization Exemption for religious reasons is valid only when notarized. A child granted a religious exemption may be excluded from child care or school during a disease outbreak. The length of time a child is excluded from child care or school will vary depending on the type of disease and the circumstances surrounding the outbreak, and could range from several days to over a month.

By signing this form, I acknowledge the Iowa Department of Public Health has published information regarding immunizations on the Department's website, including:

- Information that failure to complete the required immunizations increases the risk to my child and others of contracting, carrying, and spreading a vaccine-preventable disease; and
- Information that there are children with special health needs attending schools and child care who are unable to be vaccinated or who are at a heightened risk of contracting a vaccine-preventable disease and for whom such a disease could be life-threatening.

Signature: _____ Date: _____
Applicant, Parent or Guardian

State of _____ County of _____

This instrument was acknowledged before me on _____ Stamp or Seal
Date

by _____
Name(s) of Person(s)

Signature of Notary Public: _____

Title (or Rank for Military Personnel): _____

My commission expires: _____

June 2015

Immunization Registry Information System (IRIS)
Parent/Guardian Record Request

IRIS – Immunization Program
Lucas State Office Bldg, 5th Floor
321 E 12th Street
Des Moines, IA 50319-0075
Phone: (800)374-3958
Fax: (800)831-6292
www.idph.state.ia.us/ImmTB/Immunization.aspx

Iowa's Immunization Registry Information System (IRIS) is a statewide database of immunizations administered in Iowa from either public or private providers. IRIS helps parents, health care providers, schools and other authorized users to know an individual's immunization status.

Iowa state law [Iowa Code § 22.7(2) and 641IAC Chapter 7] provides immunization information is confidential, which can only be shared with enrolled users, including an individual's health care provider, school, child care facility, local health department, the individuals themselves or their parent/guardian if the person is a minor.

Parents and legal guardians can access records on behalf of their children until the child turns 18; after that point, the individuals themselves must request a record using the Adult Record Request Form. If you would like a copy of your child's immunization record, please complete the following **required** information and fax to your Iowa health care provider or to the IRIS Help Desk fax: 800-831-6292.

Child's Name - First: _____ Middle: _____ Last Name: _____

Address: _____ City, State, Zip: _____

Child's Date of Birth: _____ Place of Birth: _____ Gender ☐ Female ☐ Male

Please send the record to one of the following authorized users:

☐ Health Care Provider ☐ School ☐ Child care facility ☐ Myself (Parent/Guardian) ☐ Other

Recipient/To The Attention of: _____

Name of Organization: _____

Fax Number: _____ Phone Number: _____

OR

Mailing Address: _____ City, State, Zip: _____

By signing this agreement, I state that I am the parent or guardian for the child listed above:

Print Name of Parent/Guardian: _____ *Telephone Number:* _____

Signature: _____ *Date:* _____

For Office Use Only

Date Received: _____ ☐ Record Found, Date Sent: _____ Initials: _____

☐ Record Not Sent Reason: _____ Initials: _____

Household Pest Identification Form

IOWA STATE UNIVERSITY
Extension and Outreach

Submit samples, form, and payment to:
Plant & Insect Diagnostic Clinic
327 Bessey Hall
Iowa State University
Ames, IA 50011
(515) 294-0581
pidc@iastate.edu

For Office Use Only
Sample No. _____
Date Rec. _____

Please use a separate form for each pest sample. See page 2 for collecting and shipping instructions. Please contact us before sending any out-of-state samples.

	Person Sending Sample – "Submitter" ***Required***	Source or Origin of Sample – "Client" ***Leave blank if same as submitter***
Date	Collected:	Sent:
Name		
Affiliation		
Address		
City, State, Zip Code		
County		
Phone		
Email*		

*Note: When both email addresses are provided, both the client and the submitter will receive the Clinic report.

Fee: $10.00 Please include check or money order. Contact us about credit card payments.

Requested Information
- ☐ Identification
- ☐ Life cycle, habits
- ☐ If it causes damage
- ☐ Control recommendations

Number of pests found:
_____ one
_____ several
_____ 100 or more

Where was problem found?

General location (check one)	Specific location or host (plant or animal)
☐ Indoor	
☐ Yard, garden, landscape	
☐ Field crop	
☐ Livestock	
☐ Forest, woodland	
☐ Other	

Damage symptoms, additional details, comments

_____
_____
_____
_____
_____
_____

For clinic use: