

ARKANSAS CERTIFICATION OF IMMUNIZATION FOR INSTITUTIONS OF HIGHER EDUCATION

Arkansas State Law requires the following college students who were born after 1-1-57 to provide proof of immunity against measles and rubella: (1) All full-time students, and (2) any part-time students who reside on campus.

NAME OF STUDENT _____ BIRTH DATE _____ SSN _____

ADDRESS _____ PHONE _____

EDUCATIONAL INSTITUTION _____
(Name) (City)

If you were born after 1-1-57 you must:

Attach an official immunization record from another educational institution in Arkansas (high school or college).*

-OR-

Attach an immunization certificate signed by a licensed medical doctor or an authorized public health department representative.*

-OR-

Have section A or B below completed and signed.

DECLARATION

I hereby certify that the person named above (1) has received measles vaccine* on ___/___/___ and/or rubella vaccine on ___/___/___ or (2) has the acceptable medical waiver (s) for either or both vaccines checked below:

Check if
Applicable

CONDITION**

- 1.) A history of disease as confirmed by a positive laboratory test. (Measles) _____
(Rubella) _____
- 2.) Immune deficiency disease (i.e. combined immunodeficiency, agammaglobulinemia or hypogammaglobulinemia of any class. _____
- 3.) A family history of immune deficiency disease (see 1 above) unless immune deficiency has been ruled out in that person. _____
- 4.) Depression immune system due to : _____
 - a. Generalized malignancy, leukemia or lymphoma, currently or in the past.*** _____
 - b. Treatment with corticosteroids, alkylating drugs, anti-metabolites or radiation. _____
- 5.) Pregnancy _____
- 6.) Receipt of immune globulin injections in the previous 3 months. _____
(Vaccine should be given after 3 months have elapsed)
- 7.) A history of a severe systemic allergic reaction**** after exposure to neomycin. _____
- 8.) For measles, a history of severe systemic allergic reaction**** after ingestion of eggs. _____

Signed: _____
(Licensed Medical Doctor or Public Health Official) (Date)

Name of Signee: _____ Phone: _____
(Type or Print)

Address of Signee: _____

* Measels and rubella vaccines must have been received after the first birthday and after 1/1/68

** Medical exemption for conditions not listed may not be allowed unless approved by the Arkansas Department of Health. Physicians must contact: The Arkansas Department of Health, Immunization Program, 4815 West Markham Street, Little Rock, AR 72205-3867 – (501) 661-2169.

*** Physicians are encouraged to test the immune function of those thought to be “cured”; if the immune function is adequate, immunization is encouraged.

**** Severe systemic allergic reaction means a reaction involving at least one of the following symptoms: urticarial rash, swelling of the mouth and throat, difficulty breathing, hypotension, shock.

**APPLICATION FOR RELIGIOUS EXEMPTION TO IMMUNIZATION REQUIREMENTS OF
INSTITUTIONS OF HIGHER EDUCATION**

Section 4 of Act 141 reads as follows:

The provisions of this Act shall not apply if the individual furnishes to the college or university written proof from a church or denomination official that such immunization conflicts with the religious tenets and practices of such recognized church or religious denomination of which said individual is adherent or member.

To claim a religious exemption, students must demonstrate that the "religious tenets and practices" on which they base their reactions to immunization are those of a "recognized" religion. Such evidence as a permanent address, existence of a written constitution or plan of organization, a written theology or statement of beliefs, certification of tax-exempt status, and copies of legal documents filed with any governmental agency will be considered. Students must also submit an explicit and specific statement of the church's denomination's condemnation or disapproval of immunization, demonstrating why immunization is not allowed or approved. Personal or philosophical opposition to immunization without this specific doctrinal edict is not a valid basis for an exemption.

Name of Church or Religious Denomination

ADDRESSES

National Headquarters

Local Affiliate

CHURCH OFFICIAL:

NAME

TITLE

ADDRESS

PHONE

Please attach a copy of your doctrine or that part of it which specifies that immunizations conflict with tenets and practices of your church or religious denomination and explain how this conflict is derived.

Please attach a copy of any legal documents filed with a local, state, or national governmental agency.

DECLARATION

This is to certify that immunization conflicts with religious tenets and practices of

(Name of Church or Religious Denomination)

which

(Student's Name)

(Address)

(Phone)

is adherent or member.

Signature of Church or Denomination Official

City of _____ County of _____ on this _____

Day of _____ 20_____ personally appeared before me the said named

_____ to me known and known to me to be the person described in and who executed the foregoing instrument and he (or she) acknowledges that he (or she) executed the same being duly sworn by me, made oath that the statements in the application are true.

Signature of Notary Public _____

My Commission expires _____