

# Request for Exemption from Immunizations for Reasons of Conscience

Date: \_\_\_\_\_

In order to expedite your request, please print or type the name and date of birth for each child. If you are submitting this request by fax, please provide your telephone number so that we can contact you if there is a problem with the fax transmission.  
Thank You.

I wish to obtain an Exemption from Immunizations for Reasons of Conscience Affidavit Form. Please provide me with an exemption affidavit form for each of my children listed below (*maximum 5 forms per child*):

Name of Parent/Legal Guardian: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Apartment Number: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone Number (*Needed for faxed requests*) \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Legal Guardian

**Important note: No requests will be filled at the time of hand-delivery.**

First Name	Middle Name	Last Name	Birth date (mm/dd/yyyy)	Number of forms

**Please mail, fax, or hand deliver your request to:**

**Mailing Address:**  
Department of State Health Services  
Immunization Branch (MC 1946)  
P.O. Box 149347  
Austin, TX 78714-9347

**Hand Deliver:**  
Department of State Health Services  
Immunization Branch (MC 1946)  
1100 West 49<sup>th</sup> Street  
Austin, TX 78756

**Fax (512) 776-7544**

*Please provide all information requested to expedite your request. Thank you.*

