Immunization Policy

Every student enrolled in a Catholic school in the Diocese of Austin shall be immunized against vaccine preventable diseases caused by infectious agents in accordance with the immunization schedule adopted by the Texas Department of State Health (commonly known as the "Minimum State Vaccine Requirements for Texas School Entrance/Attendance"). Each year, every student must present evidence of the required immunizations from a physician or health care provider authorized to administer immunizations to the school before the first day of school. The immunizations must be current. A student who fails to present the required evidence shall not be accepted for enrollment.

There are no exceptions to the foregoing requirement unless the student presents a written statement signed by the student's physician (M.D. or D.O.) who is authorized to practice in the State of Texas, stating that:

- the physician has examined the student;*
- the physician has determined that the student has either:
  - an allergy to the vaccination(s) identified in the statement and will suffer the severe allergic reaction(s) described in the statement;
  - an immunodeficiency described in the statement and will suffer a serious health risk(s), which is also described in the statement, if the student receives the vaccination(s) specifically identified in the statement; or
  - a neurological disorder described in the statement and will suffer a serious health risk(s), which is also described in the statement, if the student receives the vaccination(s) specifically identified in the statement; and
- it is the physician's judgment that the student will pose no serious health risk to the rest of the school community if admitted to the school without receiving the identified vaccination(s).

Exceptions under this policy apply only to the vaccine(s) specifically identified in the physician's statement as causing a severe allergic reaction or a serious health risk to the student.

The physician's statement under this policy shall be in a form that is acceptable to the Superintendent of Catholic Schools of the Diocese of Austin. The superintendent shall make acceptable forms available(**Form 311**)

Immunizations are not in conflict with the Catholic faith. Conscientious objections or waivers, which may be permissible for enrollment in public schools, do not qualify as an exception to this policy (Atty. Gen. Op. GA-0420).

*A physician's exam and renewal of exemption are required upon entrance to elementary, middle school, and high school.

Adopted: 5/03
Revised: 6/08
Revised: 7/13

Diocese of Austin

Form 311 **Form 311**

Medical Exemption from Immunization Requirement/s

Date: _____

Patient Name: _____ Date of Birth: _____
(Please PRINT Full name) (mm/dd/yyyy)

School Name: _____

Address: _____

On _____ I, the undersigned physician, examined the Patient named above.
Date

Based on my examination, it is my professional judgment that the Patient named above will face *serious* health risk(s) - which are checked below - **if the Patient receives the following named vaccination/s.**

Generic name/s of the Vaccine(s) that the named patient should not receive: _____

_____

Identify Serious Health Risk(s): (Please check one)

☐ The Patient has the following allergy to the vaccination(s) listed above _____ _____ and will suffer the following severe allergic reaction if the Patient receives the vaccination: _____

☐ I have diagnosed the Patient with the following immunodeficiency: _____ _____ and if the Patient receives the vaccination the Patient will face the following serious health risk: _____

☐ I have diagnosed Patient with the following neurological disorder: _____ _____ and if the Patient receives the vaccination the Patient will face the following serious health risk: _____

Please check accordingly:

☐ Valid for school year: _____ - _____ (this exemption will be valid for one school year)

☐ This is to be a lifelong medical exemption from the Vaccine/s listed above.

☐ It is also my judgment that admitting the Patient to the School named above will pose no serious health risk to the rest of the school community, children, or staff.

MD/DO Signature:	MD/DO License #
Printed Name:	Phone:
Date of Patient Exam:	Address: City, State Zip:

***<u>IMPORTANT</u>: **This entire sheet may be faxed as long as the cover sheet is from doctors/clinic office letterhead. The physician may attach additional information for explanation.**