

Date: _____

Texas Department of Health
Immunization Division
1100 West 49th Street
Austin, TX 78756

Mail or Fax

Fax : (512) 458-7544

RE: Exemption from Immunizations for Reasons of Conscience Affidavit Form

Dear Immunization Division:

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:

Child's Full Name: _____

Date of Birth: _____

Number of additional affidavit forms needed for this child (not to exceed 5 forms): ____

Child's Full Name: _____

Date of Birth: _____

Number of additional affidavit forms needed for this child (not to exceed 5 forms): ____

Child's Full Name: _____

Date of Birth: _____

Number of additional affidavit forms needed for this child (not to exceed 5 forms): ____

Child's Full Name: _____

Date of Birth: _____

Number of additional affidavit forms needed for this child (not to exceed 5 forms): ____

Please mail my affidavit form(s) to:

Name of Parent/Legal Guardian: _____

Street address: _____

City/State/Zip: _____

Telephone Number (optional): _____

Sincerely,
