The District of Columbia Department of Health (DC Health) Religious Exemption form has been updated to include COVID-19 vaccine.

In consideration of the COVID-19 vaccine mandate for eligible students, and the need to ensure all students in the District remain up to date with all necessary or required vaccinations to attend school, DC Health has revised the religious exemption form to include a section to document a strongly held religious belief opposing vaccination.

To request a religious exemption for your student or child:

1. Please submit the name of each child, their date of birth, and the school or childcare facility where they are or will be enrolled to: doh.immunization@dc.gov. Forms may also be requested in-person Monday - Thursday, 9:00am to 3:30pm at:
   DC Health/Immunization Division
   Community Health Administration
   899 North Capitol Street NE, 3rd Floor
   Washington, DC 20002
2. CAREFULLY read the form and COMPLETE it in its entirety
   a. Print or download the document.
   b. After completion, return the signed form by scanning or uploading the document and email it to doh.immunization@dc.gov. Forms may also be returned in person (in an envelope) or by mail addressed to:
      DC Health/Immunization Division
      889 North Capitol Street NE 3rd floor
      Washington DC 20002
   c. Incomplete or non-compliant forms will be returned before being forwarded for review.
3. The process to review and document the exemption can take up to 10 business days.
4. At that time, the school nurse will be able to access the information in the DC Health immunization registry. No further documentation will be provided.

School Nurses or Immunization Points of Contact:

1. You should no longer distribute or receive religious exemption requests from student's families.
2. Forms are to be requested from and returned directly to DC Health at doh.immunization@dc.gov.
3. A student who is granted a religious exemption from any vaccine will have their vaccination record updated in the District of Columbia Immunization Information System (DOCIIS 2.0) by DC Health staff to reflect the exemption status.
4. Feel free to accept DC Health's email as evidence that the request is processing and will be reflected in DOCIIS 2.0 within 10 days.

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District of Columbia Department of Health
Annual Religious Immunization Exemption Certificate

STUDENTS in Public, Charter, Private, Parochial, Preschool, AND CHILDREN in Child Care Facilities - DC Health recognizes the importance of vaccinations for preventing disease and reducing the dangers that can come with being exposed to certain diseases. For parents who do not get vaccinations due to religious beliefs, DC Law 3-20 requires parents to write a letter that declares this sincerely held religious belief and provide it to DC Health.

This certificate may be used to request an exemption from required immunizations based on sincerely held religious beliefs. **This is a religious immunization exemption.**
This certificate will be completed annually by the parent/guardian of a student or child, or by a student greater than age 18, and will remain valid for one school year (July 1-June 30). A separate exemption certificate is necessary for each student or child.

Instructions for completing this form:
Section 1: Enter information of child or student and requestor.
Section 2: Check, Initial, and date vaccines for exemption - complete explanation letter
Section 3: Print name, sign, and date.
Attachments: Attach additional written pages and other information to this certificate to support proof of sincerely held religious beliefs, such as a signed letter from a religious/spiritual leader attended by the requestor explaining the doctrine/beliefs that prohibit the immunization(s) for which the exemption is requested.
Submission: This certificate and any attachments must be submitted directly to DC Health at doh.immunization@dc.gov OR mailed by USPS or hand-delivered to DC Health, 899 North Capitol Street NE, Washington, DC 20002, 3rd Floor.

Section 1. Child or Student's Information

Last Name: Mouse	First Name: Mickey			Date of Birth: 09/28/12
School, Childcare Facility: Laugh-O-Gram School				
Home Address:	Apt:	City:	State	Zip
Parent/Guardian/Requestor Name:		Parent/Guardian/Requestor Phone:		
Name and Address of Health Care Provider:	Address			Phone

Section 2: Immunization Exemptions: Place an "X" in a box or boxes to the left of each disease, listed below, for which you do not allow your child or student to receive the vaccine due to sincerely held religious beliefs. Initial and date the box on the right. (To be completed by parent/guardian, or student if the student is age 18 years or older).

I understand by not receiving this vaccine --- my child or student:

☐	**Hepatitis B**: Is at increased risk of developing hepatitis B if exposed to this disease. Serious symptoms and effects of this disease include jaundice (yellow skin and eyes), life-long liver problems, such as scarring and liver cancer, and death.	Initials_____ Date_____
☐	**Diphtheria (DTaP, DT, Tdap, Td):** Is at increased risk of developing diphtheria if exposed to this disease. Serious symptoms and effects of this disease include heart failure, paralysis (can't move parts of the body), breathing problems, coma, and death.	Initials_____ Date_____
☐	**Tetanus (DTaP, DT, Tdap, Tdap, Td):** Is at increased risk of developing tetanus if exposed to this disease. Serious symptoms and effects of this disease include: "locking" of the jaw, difficulty in swallowing and breathing, seizures (jerking and staring), painful tightening of muscles in the head and neck, or death.	Initials_____ Date_____
☐	**Pertussis (Whooping Cough) (DTaP, Tdap):** Is at increased risk of developing pertussis (whooping cough) if exposed to this disease. Serious symptoms and effects of this disease include severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures (jerking and staring), brain damage, and death.	Initials_____ Date_____
☐	**Haemophilus influenzae type b (Hib):** Is at increased risk of developing Hib if exposed to this disease. Serious symptoms and effects of this disease include meningitis (infection of the brain and spinal cord covering), pneumonia, severe swelling in the throat that makes it hard to breathe, infections of the blood, joints, bones, and covering of the heart, and death.	Initials_____ Date_____
☐	**Pneumococcal:** Is at increased risk if exposed to this disease. Serious symptoms and effects of this disease include chest pain with rapid breathing or difficulty breathing, a high fever, shaking, chills, excessive sweating, fatigue, confusion, and a cough with phlegm that persists or worsens, pneumonia, brain damage, and death.	Initials_____ Date_____
☐	**Polio:** Is at increased risk of developing polio if exposed to this disease. Serious symptoms and effects of this disease include paralysis (can't move parts of the body), meningitis (infection of the brain and spinal cord covering), permanent disability, or death.	Initials_____ Date_____
☐	**Measles, Mumps, Rubella (MMR):** Is at increased risk of developing measles, mumps, and/or rubella if exposed to this disease. Serious symptoms and effects of measles include pneumonia, seizures (jerking and staring), brain damage, or death. Serious symptoms and effects of mumps include meningitis (infection of the brain and spinal cord covering), swelling of the testicles or ovaries, sterility, deafness, or death. Serious symptoms and effects of rubella include rash, arthritis, and muscle or joint pain. If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, or learning disability.	Initials_____ Date_____
☐	**Varicella (Chickenpox):** Is at increased risk of developing varicella (chickenpox) if exposed to this disease. Serious symptoms and effects of this disease include severe skin infections, pneumonia, brain damage, or death.	Initials_____ Date_____
☐	**Hepatitis A:** Is at increased risk for developing hepatitis A if exposed to this disease. Serious symptoms and effects of this disease include jaundice (yellow skin or eyes), "flu-like" illness, hospitalization, or death.	Initials_____ Date_____
☐	**Meningococcal:** Is at increased risk of developing meningococcal disease if exposed to this disease. Serious symptoms and effects of this disease include severe headache, stiff neck, confusion, seizures (jerking and staring), high fever, nausea and vomiting, sensitivity of eyes to light, hearing loss, pneumonia, brain damage, or death.	Initials_____ Date_____
☐	**Human Papillomavirus (HPV):** Is at increased risk of developing human papillomavirus infection if exposed to this disease. Serious symptoms and effects of this disease include genital warts, cancer of the cervix, vulva, vagina, penis, or anus, and cancer of the throat.	Initials_____ Date_____

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☐	**COVID-19:** Is at an increased risk of contracting and spreading the virus that causes COVID-19. Serious symptoms and effects of this disease include "flu-like" illness, loss of taste and/or smell, difficulty breathing, hospitalization, and death.	Initials_____ Date_____

Please provide a personal written statement on **a)** why you do not get vaccinations based on your sincerely held religious beliefs, **b)** the religious principles that guide your decision to not get vaccinated, and **c)** whether you are opposed to all vaccinations, and if not, **d)** the religious beliefs you follow that will not allow you to get the COVID-19 vaccination.
You may attach additional documents to support your request and you may provide the name and contact information for a religious/spiritual leader who can confirm your beliefs, on letterhead. Any attachments are to be submitted with this certificate to DC Health at doh.immunization@dc.gov OR mailed by USPS or hand-delivered to DC Health, 899 North Capitol Street NE, Washington, DC 20002, 3rd Floor.

SAMPLE

Section 3: Acknowledgement and Signature	
Due to my sincerely held religious beliefs, I oppose ☐ my child ☐ myself receiving the required immunizations selected above. I am aware that if I change my mind, I can reverse this objection and obtain the required immunizations for my child or myself at any time.	
I understand that if an outbreak of a vaccine-preventable disease should occur, an exempt student will be excluded from school/childcare by the school/childcare administrative head for a period of time as determined by DC Health based on a case-by-case analysis of public health risk. For additional information please go to https://dchealth.dc.gov/service/immunization.	
Print Name of Parent/Guardian, Student if 18 years or older:	
Signature of Parent/Guardian, Student if 18 years or older:	Date:

If you have any questions or comments, please submit your questions to doh.immunization@dc.gov or call 202-576-7130.

Please note the process for submitting Medical Exemptions has not changed. A Medical Exemption can be documented on the Universal Health Certificate or physician's notes may be submitted to DC Health via the school nurse for upload through the secure Self-Service Portal.