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2025-2026 Arkansas Immunization Exemption Application Packet for Childcare or School Students

The State of Arkansas requires all children attending childcare facilities and public or private schools in the state be immunized against certain diseases. However, Act 999 of 2003 authorizes the Arkansas Department of Health (ADH) grant exemptions from these requirements.

To receive an exemption, parents or guardians must submit an Immunization Exemption Application each year to the ADH for each child. Only the 2025-2026 application will be accepted for the 2025-2026 school year. Steps include:

1. **Fill out an application.** Applications must include a notarized signature of a custodial parent or guardian.

2. **Complete an educational activity.** The law requires parents or guardians to complete an educational activity when requesting an exemption. This can be met by reading the enclosed Vaccine Information Statements from the Centers for Disease Control and Prevention (CDC).

3. **Submit the completed application to the ADH Immunization Section.**
    - Each part of the application must be completed, or it will be returned to the applicant. Returned applications will include a checklist showing the reason it could not be processed. Once fixed, the application can be resubmitted.

4. **Wait for approval.** The ADH will send the applicant a letter of approval or denial within 10 working days of receiving a completed application.
    - When approved, exemptions will be effective for the start of the fall session in 2025 and go through the summer sessions of 2026.

After an application is approved, the parent or guardian is responsible for notifying their child's daycare or school of the approved exemption request. They are also responsible for keeping the original letter for their records. A copy of the approval letter should also be placed in the child's file at the daycare or school.

Only the parent or guardian who signed the application will be able to receive information related to the exemption. For more information, please call the Immunization Section toll free at 1-800-574-4040.

Sincerely,

Sarah Labuda, MD, MPH, CTropMed®
Medical Director
Immunizations and Child Health Programs

For more information about vaccines, go to:

- Immunization Action Coalition at www.immunize.org and www.vaccineinformation.org.
- CDC at www.cdc.gov/vaccines.
- American Academy of Pediatrics at www.aap.org/immunization.
- National Network for Immunization Information at www.nnii.org.
- Vaccine Education Center at the Children's Hospital of Philadelphia at www.chop.edu/service/vaccine-education-center/home.html.
- Vaccinate Your Family at https://www.vaccinateyourfamily.org/.

You may complete the online application at https://OnlineImmunizationExemption.ADH.Arkansas.gov/

Arkansas Immunization Exemption Application
2025-2026 School Year

Please Note: To avoid processing delays, be sure to complete each part.

1. Select ONE of the following reasons for your exemption request:

☐ **MEDICAL** ☐ **RELIGIOUS** ☐ **PHILOSOPHICAL**

(For Medical - You must attach a physician's letter stating the medical reason)

2. Child's FULL Name and Contact Information:

First_____ Middle_____ Last_____

Mailing Address_____ City_____ County_____
(Include P.O. Box and/or Apartment #)

State_____ Zip_____ Gender_____ Date of Birth _____

Race: (Select up to 3) ☐ Alaskan Native or American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other

Ethnicity: (Select 1) ☐ Hispanic or Latino ☐ Not Hispanic or Latino

3. Childcare or School Information: Select ONE: ☐ Public ☐ Private

Select ONE: ☐ Home/Virtual ☐ Childcare ☐ Preschool ☐ Elementary ☐ Middle ☐ Jr. High ☐ Sr. High

Facility/School_____ Public School District_____
(Home school, childcare or private school - Need school affiliation or curriculum)

Mailing Address_____ City_____ County_____

State_____ Zip_____ Grade_____

FIRST DAY OF ATTENDANCE FOR 2025-2026 SCHOOL YEAR:_____/_____/20_____
Month/ Day/ Year

4. Parent/Guardian FULL Name and Contact Information:

First_____ Middle_____ Last_____

Mailing Address_____ City_____ County_____
(Include P.O. Box and/or Apartment #)

State_____ Zip_____ Daytime Phone (_____)_____-_____ E-mail_____

Statement of Refusal to Vaccinate

Select the vaccine(s) that you **DO NOT** want your child to receive.

☐ **DTaP (Diphtheria, Tetanus & Pertussis) vaccine**

I understand by not receiving the DTaP vaccine, the child listed here is at risk of a sore throat, fever, heart complications, feeding problems, paralysis, pertussis (whooping cough), respiratory complications, coma, and death.

☐ **Hib (*Haemophilus influenzae* Type b) vaccine**

I understand by not receiving the Hib vaccine, the child listed here is at risk of skin and throat infections, ear infections, meningitis, pneumonia, blood infections, arthritis, permanent brain damage, and death.

☐ **Hepatitis A vaccine**

I understand by not receiving the Hepatitis A vaccine, the child listed here is at risk of yellow skin or eyes, "flu-like" illness, abdominal pain, loss of appetite, nausea, joint pain, and life-long liver problems, such as scarring of the liver and cancer or the need for a liver transplant, and death.

☐ **Hepatitis B vaccine**

I understand by not receiving the Hepatitis B vaccine, the child listed here is at risk of yellow skin or eyes, "flu-like" illness, abdominal pain, loss of appetite, nausea, joint pain, and life-long liver problems, such as scarring of the liver and cancer or the need for a liver transplant, and death.

☐ **MMR (Measles, Mumps & Rubella) vaccine**

I understand by not receiving the MMR vaccine, the child listed here is at risk of a rash, fever, cough, diarrhea, muscle aches, ear infections, pneumonia, headaches, seizures, meningitis, brain infections, inflammation of the testicles and ovaries, sterility, arthritis, inflammation of the pancreas, permanent deafness, brain damage, and death. Birth defects if acquired while pregnant include deafness, cataracts, heart defects, mental retardation, and liver and spleen damage in the baby.

☐ **Meningococcal (serogroup A, C, W, Y) vaccine**

I understand by not receiving the Meningococcal vaccine, the child listed here is at risk of meningitis, which is a severe infection of the covering of the brain and the spinal cord. The child is also at risk of blood infections, problems with their nervous system, loss of arms or legs, permanent deafness, suffer from strokes or seizures, and death.

☐ **Pneumococcal vaccine**

I understand by not receiving the Pneumococcal vaccine, the child listed here is at risk of severe disease including meningitis, which is a severe infection of the covering of the brain and the spinal cord. The child is also at risk of blood infections, pneumonia, permanent deafness, brain damage, and death.

☐ **Polio vaccine**

I understand by not receiving the Polio vaccine, the child listed here is at risk of a fever, sore throat, nausea, headaches, stomachaches, stiffness, paralysis that can lead to permanent disability, and death.

☐ **Td (Tetanus, Diphtheria) vaccine**

I understand by not receiving the Td vaccine, the child listed here is at risk of seizures, serious neuromuscular disease, heart problems, and death.

☐ **Tdap (Tetanus, Diphtheria, Pertussis) vaccine**

I understand by not receiving the Tdap vaccine, the child listed here is at risk of pneumonia, pertussis (whooping cough), seizures, inflammation of the brain, serious neurological complications, and death.

☐ **Varicella (Chickenpox) vaccine**

I understand by not receiving the Varicella vaccine, the child listed here is at risk of a rash, fever, severe skin infections, scars, pneumonia, seizures, brain infection, and death.

I have decided to decline the required vaccine(s) listed above, and I have checked the appropriate box(es) for the vaccine(s) I want to decline.

I understand that if my child is exposed to a disease that vaccines can prevent, he or she may expect to be excluded from childcare or school. This exclusion could last for 21 days or longer, as determined by the ADH. This step is to protect both my child and others.

I also understand that I may change my decision and accept vaccination for my child at any time in the future. Under penalty of law, I affirm that I have received and reviewed the entire application packet. This includes the Vaccine Information Statements from the Centers for Disease Control and Prevention, which explain the risks of not vaccinating my child. Despite this information, I still request an exemption.

I understand that only the custodial parent or guardian who completes this application and provides a notarized signature can receive information related to this exemption.

Signature _____

Parent/Guardian

Notary Public

State of_____County of _____

On this___day of_____, 20___, before me personally appeared _____

Parent/Guardian

known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed the same for the purposes therein contained.

In witness whereof, I hereunto set my hand and official seal.

OFFICIAL SEAL

Signature _____

Notary Public

My Commission Expires: _____

Please Return Application: ***CHOOSE ONE METHOD ONLY***

MAIL to: **Arkansas Department of Health**
ATTN: Exemptions
4815 West Markham, Mail Slot #48
Little Rock, AR 72205
*EMAIL to:***Immunization.Section@arkansas.gov**
*FAX to:***(501)661-2300**