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| CSO-1575 (2-18) | ARIZONA DEPARTMENT OF CHILD SAFETY | R:\DCS_round_logo_K.jpg |
|  | **IMMUNIZATION EXCEPTION FOR LICENSE AMENDMENT**  |
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| The purpose of the Immunization Exception for License Amendment form is to determine whether a specific immunized child under five (5) years of age is at a heightened health risk if placed in a foster home where other children living in the home are not fully immunized. |
| FOSTER PARENT’S NAME:      | QCID:      |
| **CHILDREN CURRENTLY RESIDING IN THE HOME** |
| Name | Sex | Age | Current immunizations *(Immunization verification form can be substituted and attached)* |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
| *\*If more space is needed, use page 2 of form* |
| **CHILD TO BE PLACED IN THE HOME** |
| Name | Sex | Age | Current immunizations *(Immunization verification form can be substituted and attached)* |
|       | [ ]  M [ ]  F |       |       |
| Does the child to be placed have any special health needs that would make them more vulnerable than a typical child of their age? |
| [ ]  Yes [ ]  No *If Yes, Explain below* |
|       |
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| Based on the information provided to me, it is my professional medical opinion the child to be placed **is not** at a heightened health risk if placed in this foster home with the children currently residing in the home. |
| PHYSICIAN’S NAME: *(Please Print)*      | PHONE NUMBER:      | LICENSE NUMBER:      |
| ADDRESS: *(No., Street, City, State, ZIP)*      |
| PHYSICIAN’S SIGNATURE: | DATE: |
|       |       |
| **PLEASE RETURN THIS FORM TO:** |
| AGENCY SPECIALIST’S NAME:      | EMAIL ADDRESS:      |
| AGENCY NAME:      | AGENCY PHONE:      |
| ADDRESS: (No., Street, City, State, ZIP)      |

See reverse for EOE/ADA/GINA disclosure.

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| **CHILDREN CURRENTLY RESIDING IN THE HOME** |
| Name | Sex | Age | Current immunizations *(Immunization verification form can be substituted and attached)* |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |
|       | [ ]  M [ ]  F |       |       |

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for Department services is available upon request. • Ayuda gratuita con traducciones relacionadas con los servicios del DCS está disponible a solicitud del cliente.