MEDICAL REQUEST FOR IMMUNIZATION EXEMPTION

Instructions for the Requesting Physician

This form must be completed by a NYS-licensed physician. The exemption must be based Advisory Committee on Immunization Practices guidelines. Medical exemptions are granted for no more than one year and must be renewed at the start of each school-year. Department of Health physicians may request additional information.

The following are **NOT** valid contraindications to **ANY** routine vaccine:

- Egg allergy, even if anaphylactic, is not a valid contraindication to MMR, influenza, or any other vaccine.
- Autism and/or developmental delay in the child or family member.
- Contact with immunosuppressed persons by a healthy individual.
- Pregnancy in the household or contact with a pregnant woman.

Medical Exemption Request

As the student's physician, I request a medical exemption for (**student name**) _____ for the following required immunization(s). I certify that the particular immunization(s) will be detrimental to the child's health:

						For children up to the 5th birthday		
☐ Hepatitis B	☐ DTaP/Tdap/Td	☐ Polio	☐ MMR	☐ Varicella	☐ MenACWY	☐ PCV13	☐ Hib	☐ Influenza

Explanation for exemption request for each vaccine (if more than one)

Include diagnosis and/or treatment precluding vaccination, date of event, expected duration of contraindication:

_____

_____

_____

_____

_____

_____

Physician Name:	**NYS License # NY** __ __ __ __ __ __	
Physician Signature:	**Degree (MD/DO):**	**Date**__ __ / __ __ / __ __ __ __
Office Phone (__ __ __) __ __ __ - __ __ __ __ Ext __ __ __ __ **Cell Phone** (__ __ __) __ __ __ - __ __ __ __		**Stamp**

Parent/Guardian Consent for Release of Information

I, (**parent/guardian name**)_____ authorize (**physician name**)_____ to provide physicians and nurses of the New York City Departments of Health and Mental Hygiene and Education and their medical consultants with information contained in my child's medical record, including, but not limited to copies of laboratory and or other examinations supporting this request for medical exemption for required immunizations.

Parent/Guardian's signature _____**Date** __ __ / __ __ / __ __ __ __

For school/facility use	DOE Sites	Non-DOE sites
Student Name:	OSIS #	Facility Name:
Date of Birth __ __ / __ __ / __ __ __ __	ATS DBN	Facility Contact info: