



# MEDICAL REQUEST FOR IMMUNIZATION EXEMPTION



Student Information	DOE Sites	Non-DOE Sites: Facility Information
Student Name:	OSIS #	Facility Name:
Date of Birth ___/___/_____ Student Address:	ATS DBN	Contact name/title: Phone:                      FAX: Address:

## Instructions for the Requesting Physician

This form must be completed and signed by a **physician** licensed in New York State and be based on [Advisory Committee on Immunization Practices' guidelines](#), in accordance with NYS Public Health Law Section 2164. Medical exemptions are granted for no more than one year and requests must be resubmitted annually. NYC Department of Health physicians review all medical exemption requests and may request additional information. Parental concerns will not be considered without medical documentation.

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.
- Mild, acute illness (e.g. low-grade fever, cold, upper respiratory illness, diarrhea, otitis media).
- Contact with immunosuppressed persons by a healthy individual.
- Pregnancy in the household or contact with a pregnant woman.
- Non-severe, life-threatening allergic reaction to vaccination or history of allergies in a relative.
- Prior influenza A and/or B infection (influenza vaccine still required).
- Controlled seizures (with or without medication) or a history of seizures in a relative.

## Medical Exemption Request

As the student's physician, I request a medical exemption for (**student name**) \_\_\_\_\_  
**date of birth** \_\_\_/\_\_\_/\_\_\_\_ for the following required immunization(s). I certify under penalty of violation of NYS Public Health Law Section 2164 that the particular immunization(s) will be detrimental to the child's health:

<input type="checkbox"/> Hepatitis B <input type="checkbox"/> DTaP <input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> Polio <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> MenACWY	<b>For children up to the 5<sup>th</sup> birthday</b> <input type="checkbox"/> PCV13 <input type="checkbox"/> Hib <input type="checkbox"/> Influenza
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**Explanation for exemption request for each vaccine(s).** Specify diagnosis and/or treatment precluding vaccination, date of event(s), and expected duration of contraindication. Please include supporting documentation. Attach additional pages if needed.

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<b>Physician Name:</b>	<b>NYS License # NY</b> _____	
<b>Physician Signature:</b>	<b>Degree</b> ( <input type="checkbox"/> MD <input type="checkbox"/> DO)	<b>Date</b> ___/___/____
<b>Office Phone</b> (____) _____ - _____ Ext _____ <b>Cell Phone</b> (____) _____ - _____	<b>Stamp</b>	

## Parent/Guardian Consent for Release of Information

I, (**parent/guardian name**) \_\_\_\_\_ authorize (**physician name**) \_\_\_\_\_ to provide the New York City Departments of Health and Education with information contained in my child's medical record, including, but not limited to laboratory or other records supporting this request.

**Parent/Guardian's signature** \_\_\_\_\_ **Date** \_\_\_/\_\_\_/\_\_\_\_