MEDICAL REQUEST FOR IMMUNIZATION EXEMPTION

Student Information	DOE School Sites	Non-DOE School Sites
Student Name:	OSIS #	School/Facility Name:
Date of Birth __/__/____ Student Address:	ATS DBN	School 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' recommendations and guidelines, in accordance with NYS Public Health Law Section 2164. Parental concerns about immunizations do not constitute a valid medical exemption. Medical exemptions are granted for no more than one year and requests must be resubmitted annually. NYC Department of Health medical providers review all medical exemption requests and may request additional information. Note: students on home instruction are required to be vaccinated in accordance with the NYS Public Health Law Section 2164.

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.
- Controlled seizures (with or without medication).
- Mild, acute illness (e.g., low-grade fever, cold, upper respiratory illness, diarrhea, otitis media).
- Prior influenza A and/or B infection (influenza vaccine still required for children up to the 5th birthday).
- Contact with immunosuppressed persons by a healthy individual.
- Pregnancy in the household or contact with a pregnant woman.
- Family history of any vaccine reaction(s) or history of allergies (in a relative).
- Family history of seizures (in a relative).
- Parental requests to delay or withhold vaccinations will not be considered.

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:

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

Explanation for exemption request for each vaccine(s). please attach supporting documentation if needed.

Diagnosis/Event/Treatment:

Date of Diagnosis/Event: Expected Duration of Contraindication:

Physician Name:	**NYS Physician 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 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** __ __/__ __/__ __ __ __