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. Medical exemptions must be resubmitted at the start of each school year. 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:

	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(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.

_____
_____
_____
_____
_____
_____

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 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** __ __ / __ __ / __ __ __ __