NYC Department of Education

MEDICAL REQUEST FOR IMMUNIZATION EXEMPTION

FOR DOE USE ONLY

Student's name _____ DOB ___/___/___

OSIS # | | | | | | | | | | ATS DBN | | | | | | |

FOR THE USE OF REQUESTING MEDICAL PROFESSIONAL

INSTRUCTIONS: This form is to be completed by the student's treating physician who must be licensed in NYS. The medical basis for exemption must be based on guidance from the Centers for Disease Control and Prevention (CDC), Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics (AAP) Red Book.

Failure to provide contact information and/or sufficient documentation will delay the review process. Requests for additional information, made either by telephone or in writing must be received by the Office of School Health within 2 weeks or the request for medical exemption will be denied.

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

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

NOTE:

- Exemption from MMR based on egg allergy will not be accepted. Guidelines are explicit that egg allergy, even if anaphylactic, is not a valid contraindication.
- Autism and/or developmental delay in the child or family member is not a valid reason for exemption for any vaccine and will not be accepted.
- Contact with immunosuppressed persons by a healthy individual is not a valid contraindication for exemption and will not be accepted.
- Pregnancy in the household or contact with a pregnant woman is not a valid contraindication for exemption and will not be accepted.
- Medical exemptions are no more than one year and must be renewed at the start of each school year.

Explanation:_____

_____

I am the student's physician PRINT CLEARLY

NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Physician's original signature _____ Degree: _____ License # | | | | | | | | |

_____ Physician

_____ Fellow

_____ Resident

Stamp

Contact information

Direct telephone line ___/___/___ ___/___/___ ___/___/___/__ ext __/__/__/__ Cell ___/___/___ ___/___/___ ___/___/___/___

Date _____

PARENT/GUARDIAN CONSENT FOR RELEASE OF INFORMATION

I authorize _____ (health professional) to provide physicians and nurses of the New York City Department of Health and Mental Hygiene and the New York City Department of 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 _____

Parent/Guardian's name (PRINT) _____ Date _____

FOR OFFICE OF SCHOOL HEALTH USE ONLY

Exemption ____ APPROVED _____ DENIED Length of exemption:_____

Physician comments: _____

_____

Reviewed by: _____ Date: _____

Revised 09/26/17