MEDICAL REQUEST FOR IMMUNIZATION EXEMPTION

INSTRUCTIONS: This form is to be completed by the student's treating physician/nurse practitioner 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.

_____ is under my care for _____

Student's name (PRINT) Diagnosis

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

_____ _____ _____ _____ _____ _____

Provide details of the medical basis for the requested exemption(s) below. Additional documentation to support the request may be attached. If the request is based on immune serology (titers) attach a copy of the laboratory documentation.

- 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 for MMR vaccine.
- 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.

_____

_____

_____

I am the student's treating health care practitioner

NAME

Practitioner's original signature _____ Degree: _____ License #

_____ Attending physician Stamp

_____ Nurse practitioner

_____ Fellow _____ Resident

Contact information

Direct telephone line _/_/_ _/_/_ _/_/_/_ ext _/_/_/_ Cell _/_/_ _/_/_ _/_/_/_ Other _/_/_ _/_/_ _/_/_/_

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 exemption for required immunizations.

Parent/Guardian's signature _____

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

FOR DOE USE ONLY

Student name _____ DOB ___/___/___ OSIS ID# DBN

FOR OFFICE OF SCHOOL HEALTH USE ONLY

Physician's comments: _____

_____

_____

Proof of immunity (serology) confirmed for (circle): Measles Mumps Rubella Varicella Hepatitis B Polio (3 types)

Documentation of disease confirmed for Varicella

Exemption ____ APPROVED _____ DENIED Length of exemption (circle) Permanent Yearly Other (specify) _____

Date _____ OSH Physician Name _____ OSH Physician signature _____

Revised 09/22/2015