

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 in accordance with the 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 5 th birthday			
<input type="checkbox"/> DTaP	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> Polio	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> MMR	<input type="checkbox"/> Varicella	<input type="checkbox"/> MenACWY	<input type="checkbox"/> PCV	<input type="checkbox"/> Hib	<input type="checkbox"/> 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 <input type="checkbox"/> MD <input type="checkbox"/> DO	Date _____
Office Phone (_____) _____ - _____ Ext _____	Stamp	
Cell Phone (_____) _____ - _____		

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 _____