Department of Education

# Medical Request for Immunization Exemption

Instructions: This form is to be completed by the student's treating physician (must be licensed in NYS). The medical basis for exemption request should be based on medical literature such as AAP Red Book, ACIP or CDC guidance. Failure to provide contact information or sufficient written medical documentation will delay the review process. Requests for additional information, either by phone or in writing, that are not responded to within 2 weeks will result in denial of exemption request.

_____is under my care for: _____.
(Student's name) (Diagnosis)

**A. I request that this student be excused from having the following required immunization(s) and certify that the particular immunization(s) may be detrimental to the child's health:**
1._____ 2._____ 3._____ 4. _____ 5._____

B. **Detail medical basis for exemption request below.** (If request based on titers, please include copy of lab documentation). **NOTE: REQUESTS FOR MEDICAL EXEMPTION FROM MMR BASED ON EGG ALLERGY WILL *NOT* BE ACCEPTED. NATIONAL GUIDELINES ARE CLEAR THAT EGG ALLERGY (EVEN IF ANAPHYLACTIC) IS *NOT* A VALID CONTRAINDICATION FOR MMR VACCINATION.** (Physician may attach a letter detailing the medical basis for the exemption request).

_____

_____

_____

C. I am this student's treating healthcare provider and can be reached via Telephone: _____ and/or Beeper / Cell _____ on the following days and times:
Mon___to ___(hrs) Tues___to___(hrs) Wed___to___(hrs) Thur___to___(hrs) Fri___to___(hrs)

Provider's original signature _____ License#_____
Print Name/ Degree_____ Date_____

**PARENT/GUARDIAN CONSENT FOR RELEASE OF MEDICAL INFORMATION**

I authorize _____ (name of doctor) to provide physicians and nurses employed by the New York City Department of Education and the Department of Health and Mental Hygiene and their medical consultants with information contained in my child's medical record, including, but not limited to, copies of laboratory or other examinations supporting the exemption of my child from having required immunizations.

Parent/Guardian's signature: _____

Parent/Guardian: Print name: _____Date _____

**FOR DOE USE ONLY**

Student's Name_____DOB_____ID#_____School DBN_____

**FOR OFFICE OF SCHOOL HEALTH USE ONLY**

Medical review completed by Dr._____ Date _____
Physician Comments_____

_____

_____

Exemption Status: ___ Denied ___ Approved Length of exemption: Permanent _____ Yearly _____
Date of Renewal if less than yearly: _____