Parents requesting Medical Exemptions from required immunizations must have their child's doctor complete the form below. The form must be completed every school year. Religious exemptions are no longer allowed in New York State.

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization/Division of Epidemiology

Immunization Requirements for School Attendance
Medical Exemption Statement for Children 0-18 Years of Age

NOTE: THIS EXEMPTION FORM APPLIES ONLY TO IMMUNIZATIONS REQUIRED FOR SCHOOL ATTENDANCE

Instructions:

1. Complete information (name, DOB etc.).
2. Indicate which vaccine(s) the medical exemption is referring to.
3. Complete contraindication/precaution information.
4. Complete date exemption ends, if applicable.
5. Complete medical provider information. Retain copy for file. Return original to facility or person requesting form.

1. Patient's Name _____
2. Patient's Date of Birth _____
3. Patient's Address _____
4. Name of Educational Institution _____

Guidance for medical exemptions for vaccination can be obtained from the contraindications, indications, and precautions described in the vaccine manufacturers' package insert and by the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP) available in the Centers for Disease Control and Prevention publication, Guide to Vaccine Contraindications and Precautions. This guide can be found at the following website: **http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm**.

Please indicate which vaccine(s) the medical exemption is referring to:

- ☐ Haemophilus Influenzae type b (Hib)
- ☐ Polio (IPV or OPV)
- ☐ Hepatitis B (Hep B)
- ☐ Tetanus, Diphtheria, Pertussis (DTaP, DTP, Tdap)
- ☐ Measles, Mumps, and Rubella (MMR)
- ☐ Varicella (Chickenpox)
- ☐ Pneumococcal Conjugate Vaccine (PCV)
- ☐ Meningococcal Vaccine (MenACWY)

Please describe the patient's contraindication(s)/precaution(s) here: _____

Date exemption ends (if applicable)

A New York State licensed physician must complete this medical exemption statement and provide their information below:

Name (print) _____ NYS Medical License # _____

Address _____

_____ Telephone _____

Signature _____ Date _____

For Institution Use ONLY: Medical Exemption Status ☐ Accepted ☐ Not Accepted Date: _____

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