

# 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:

- |   |   |
|---|---|
| <input type="checkbox"/> Haemophilus Influenzae type b (Hib)              | <input type="checkbox"/> Measles, Mumps, and Rubella (MMR)    |
| <input type="checkbox"/> Polio (IPV or OPV)                               | <input type="checkbox"/> Varicella (Chickenpox)               |
| <input type="checkbox"/> Hepatitis B (Hep B)                              | <input type="checkbox"/> Pneumococcal Conjugate Vaccine (PCV) |
| <input type="checkbox"/> Tetanus, Diphtheria, Pertussis (DTaP, DTP, Tdap) |   |

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: \_\_\_\_\_