

## 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:

- Complete information (name, DOB etc.).
  - Indicate which vaccine(s) the medical exemption is referring to.
  - Complete contraindication/precaution information.
  - Complete date exemption ends, if applicable.
  - Complete medical provider information. Retain copy for file. Return original to facility or person requesting form.
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- Patient's Name
  - Patient's Date of Birth
  - Patient's Address
  - 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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