Request for Medical Exemption to Immunization Form

Name of Student____________________________________________________________

Name of Parent(s)/Guardian(s) (If student is under 18) ____________________________

HEALTH CARE PROVIDER

Name:________________________________________
Address:________________________________________
Phone:________________________________________
Email:________________________________________

This form is for your use in applying for a medical exemption to Public Health Law immunization requirements for _______________________.

(Name of Student)

The purpose of this form is to the medical basis for the request. In the area provided below, please write your statement. The statement must indicate the medical reason why the above named student is exempt from the immunization(s) required under New York State Public Health Law (PHL) Section 2165.

You may attach to this form additional written pages or other supporting materials if you so choose.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please continue your statement on page 2
Request for Medical Exemption to Immunization Form

Please sign in the space provided below.

______________________________
Signature of Health Care Provider

______________________________
Date

______________________________
Print

______________________________
Signature of Student
(Parent(s)/Guardian(s) must sign, if student is under 18)

______________________________
Date