Sherman Central School
127 Park Street
Sherman, New York 14781

Medical Exemption for Required Immunization Request Form

NYSDOH Public Health Law Section 2164(7)(a) requires adequate dose or doses of immunizing agents against poliomyelitis, mumps, measles, diphtheria, rubella, varicella, Haemophilus influenza type b (Hib), pertussis, tetanus, and hepatitis B for school entry.

New York State Law Section 66-1.3 (7) (c)-Requirement for School Admission permits medical exemption to required immunizations if the parent provides a certificate from a physician, licensed to practice medicine in New York State, that one or more of the required immunizations may be detrimental to the child's health.

The Centers for Disease Control's (CDC) resources on contraindications to vaccination can be found at: http://www.immunize.org/catg.d/p3072a.pdf .

Your certificate should include:

- The specific immunization that is medically contraindicated
- The reason for the medical contraindication
- The duration of the request

Please note that a physician should not request a permanent exemption unless you anticipate the child to have a life-long anaphylactic reaction to a given vaccine or one of its components, which cannot be desensitized, or the child has some other severe chronic medical condition you do not expect to resolve. All other requests should be temporary and require at minimum your annual re-assessment, if not sooner when the condition resolves.

To Be Completed By Health Care Provider

Student Name: _____DOB: _____ Grade: _____

Teacher/HR: _____ School: _____

Name of Immunization which cannot be administered _____
Reason for exemption: _____
Duration of exemption: □ Academic year □ Other_____

❑ This immunization will never be given because of the following medical contraindications:

_____

❑ Unless otherwise advised, this immunization will be given on _____

Name of Licensed Prescriber (Please Print) _____

Prescriber's Signature _____Date _____ Phone _____

Please return this form to:

School Nurse: _____ School _____

Phone: _____ Fax: _____ Email _____

This document must be filed with the student's cumulative health record. It must be renewed annual prior to the beginning of the school year, in September. Please take this form to your Primary Care Physician and have it completed. It can then be faxed to (716) 761-6119 or mailed to the attention of Mrs. Thorsell at the school address listed above.

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