STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH
BUREAU FOR PUBLIC HEALTH
Commissioner's Office

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Commissioner & State Health Officer

REQUEST FOR MEDICAL EXEMPTION FROM COMPULSORY IMMUNIZATION FORM

(Incomplete or non-legible forms will be returned)

Name of Student:	Birth Date:
Parent/Guardian:	Phone Number:
Address of Student:	
Name of School and County:	
School Nurse and Contact Information:	
Healthcare Provider Requesting Exemption:	
Address and Phone Number of Healthcare Provider:	

Select the immunizations for which the exemption is requested:

New school entry:

☐ Diphtheria
☐ Tetanus
☐ Pertussis
☐ Polio
☐ Measles
☐ Mumps
☐ Rubella
☐ MMR
☐ Varicella
☐ Hepatitis B

7th Grade:

☐ Tdap Booster
☐ Meningococcal

12th Grade:

☐ Tdap Booster
☐ Meningococcal

Is the requested exemption:

- ☐ Permanent
- ☐ Temporary
  - o Expected duration: ____________________

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Why does this child need an immunization exemption? If the request is based on a previous reaction, please attach medical records. If the child is on immunosuppressive medication, please include relevant diagnosis and duration of therapy.

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Is there further information you feel is relevant to this request?

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Are the vaccinations documented in this child's record in the West Virginia Statewide Immunization Information System (WVSIIS) complete?

- ☐ Yes
- ☐ No*
- ☐ Unsure*

*If No or Unsure, please include a copy of the child's immunization record with this request.

Requesting Healthcare Provider (Print Name) ______________________________

Signature ______________________________

Date ______________________________