



**STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES**

**Bureau for Public Health**

**Office of Epidemiology and Prevention Services**

Jeffrey H. Coben, MD  
Int. Cabinet Secretary

Matthew Q. Christiansen, MD, MPH  
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:

- |                                     |                                  |                                      |
|-------------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Measles | <input type="checkbox"/> Varicella   |
| <input type="checkbox"/> Tetanus    | <input type="checkbox"/> Mumps   | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Pertussis  | <input type="checkbox"/> Rubella |                                      |
| <input type="checkbox"/> Polio      | <input type="checkbox"/> MMR     |                                      |

7<sup>th</sup> Grade:

- Tdap Booster  
 Meningococcal

12<sup>th</sup> Grade:

- Tdap Booster  
 Meningococcal

Is the requested exemption:

- Permanent  
 Temporary

o Expected duration: \_\_\_\_\_

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Request For Medical Exemption From Compulsory Immunization Form  
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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 \_\_\_\_\_