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
- [ ] Varicella
- [ ] Hepatitis B

**7th Grade:**
- [ ] Tdap Booster
- [ ] Meningococcal

**12th Grade:**
- [ ] Tdap Booster
- [ ] Meningococcal

Is the requested exemption:
- [ ] Permanent
- [ ] Temporary
  - [ ] Expected duration: _____________________________

*** Continued on Page 2 ***
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 (WVSIIIS) 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 ________________________________