REQUEST FOR MEDICAL EXEMPTION FROM COMPULSORY IMMUNIZATION FORM
(Incomplete or non-legible forms will be returned)

<table>
<thead>
<tr>
<th>Name of Student:</th>
<th>Birth Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian:</td>
<td>Phone Number:</td>
</tr>
<tr>
<td>Address of Student:</td>
<td></td>
</tr>
<tr>
<td>Name of School and County:</td>
<td></td>
</tr>
<tr>
<td>School Nurse and Contact Information:</td>
<td></td>
</tr>
<tr>
<td>Healthcare Provider Requesting Exemption:</td>
<td></td>
</tr>
<tr>
<td>Address and Phone Number of Healthcare Provider:</td>
<td></td>
</tr>
</tbody>
</table>

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
  - Expected duration: _______________________

*** Continued on Page 2 ***

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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.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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 _____________________________________________________

Rev. 10.18.2022