STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Public Health
Office of Epidemiology and Prevention Services

Bill J. Crouch
Cabinet Secretary

Ayne Amjad, 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:

- ☐ 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: _____

*** 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.

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 (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 _____