



Instructions for filing for a medical exemption from submitting proof of Immunization.

The New York State Department of Health's [Immunization Handbook for PostSecondary Institutions](#) provides the following information regarding Medical Exemptions for students:

Medical Exemption

"If a licensed physician, physician assistant, or nurse practitioner, or licensed midwife caring for a pregnant student certifies in writing that the student has a health condition which is a valid contraindication to receiving a specific vaccine, then a permanent or temporary (for resolvable conditions such as pregnancy) exemption may be granted. This statement must specify those immunizations which may be detrimental and the length of time they may be detrimental. Provisions need to be made to review records of temporarily exempted persons periodically to see if contraindications still exist. In the event of an outbreak, medically exempt individuals should be protected from exposure. This may include exclusion from classes or campus."

In general, the following persons should not receive Measles, Mumps, or Rubella Vaccine without checking with a doctor.

- Previous anaphylactic reaction to this vaccine or to any of its components.
- Pregnancy or possibility of pregnancy within 4wks.
- Severe immunodeficiency (e.g., hematologic and solid tumors; receiving chemotherapy; congenital immunodeficiency; long-term immunosuppressive therapy; or severely symptomatic HIV).

Note: HIV infection is NOT a contraindication to MMR for those who are not severely immunocompromised

REQUEST FOR MEDICAL EXEMPTION TO IMMUNIZATION FORM

This form must be submitted for all requests for exemption from immunization requirements. Please review Instructions for filing for a medical exemption from submitting proof of Immunization. In the event of an outbreak, medical exempt individuals may be inhibited from physical campus access.

Student Name: _____
Student ID#: _____

Date of Birth: _____

In addition to this form, provide a signed statement from a licensed physician, physician assistant, or nurse practitioner, or licensed midwife specifying the immunizations which are detrimental to your health and the length of time these immunizations must be waived. The statement must be signed within the last two years.

Health Care Provider Info

Name: _____
Address: _____
Phone #: _____

Health Care Provider License Number &
or Stamp:

Waiver effective until _____

____ Confirm that you have read the following *What You Need to Know* documents

- [What You Need to Know- Measles, Mumps, Rubella Vaccines](#)
- [What You Need to Know- Meningococcal Vaccine](#)

I hereby affirm the truthfulness of the forgoing statement.

Student Signature

Date

Parent or Guardian Signature, if student is under 18 years of age

Date

**PLEASE COMPLETE, SIGN AND UPLOAD THIS FORM TO UNIVERSITY
HEALTHCARE'S SECURE PATIENT PORTAL**