



**REQUEST FOR REVIEW OF NON-VACCINATION IMMUNITY TO SATISFY
IMMUNIZATION REQUIREMENTS**



Student's Name	Date of Birth ___ / ___ / _____
OSIS #	ATS DBN

INSTRUCTIONS FOR THE REQUESTING MEDICAL PROVIDER

New York State Public Health Law §2164 allows for laboratory documentation of immunity to satisfy the immunization requirements for school/childcare attendance for measles, mumps, rubella, varicella, and hepatitis B. **Poliomyelitis serology is no longer acceptable evidence of immunity. Serologic results are not acceptable proof of immunity to diphtheria, tetanus or pertussis.** Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella (chicken pox) disease is acceptable proof of immunity to varicella only. Parent history of varicella disease is not sufficient.

As the child's medical provider, I certify that this child has (select all that apply):

Lab evidence of immunity*: Measles Mumps Rubella Varicella Hepatitis B

Varicella disease history*: Varicella Disease

* You must include one of the following documents for laboratory evidence of immunity or varicella documentation:

- A copy of the laboratory result including student name, DOB, test results and either reference range or qualitative result (e.g. positive, immune); you must sign the document and must specify which results indicate laboratory immunity (e.g., 'Measles immune, rubella immune').
- A printout of the child's immunization history page from the Citywide Immunization Registry indicating that the child had provider-documented varicella disease.

I am the student's treating health care practitioner

Physician Name:	NYS License # _____
Physician Signature:	Degree: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA
Office Phone (_____) _____ - _____ Ext _____	Stamp
Cell Phone (_____) _____ - _____	
Date ___ / ___ / _____	

PARENT/GUARDIAN CONSENT FOR RELEASE OF INFORMATION

I authorize _____ (health professional) to provide physicians and nurses of the New York City Department of Health and Mental Hygiene and the New York City Department of Education and their medical consultants with information contained in my child's medical record, including, but not limited to, copies of laboratory and or other examinations supporting this request for medical exemption for required immunizations.

Parent/Guardian Name: _____

Parent/Guardian's signature _____ Date: ___ / ___ / _____

NYC DOHMH USE ONLY

Confirmed immunity	<input type="checkbox"/> MEASLES	<input type="checkbox"/> MUMPS	<input type="checkbox"/> RUBELLA	<input type="checkbox"/> VARICELLA	<input type="checkbox"/> HEP B	<input type="checkbox"/> VARICELLA DISEASE
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Reviewed by _____ Date ___ / ___ / _____