# MEDICAL WAIVER REQUEST
## for the Mandatory Immunizations to Attend Schools and Child Caring Facilities

Wyoming Department of Health, Immunization Unit, Attn: Waivers
6101 Yellowstone Road, Suite 420, Cheyenne, WY 82002
307-777-7952 • www.immunizewyoming.com

The Centers for Disease Control and Prevention (CDC) and the Wyoming Department of Health recognize immunization as one of the most effective tools in preventing disease and reducing the risks associated with exposure to certain diseases.

Wyo. Stat. Ann. § 21-4-309 allows for the submission of waivers based on religious beliefs and medical contraindications only. Wyoming statute does NOT allow for the approval of waiver requests based on philosophical or personal beliefs.

**SUBMIT WAIVER REQUESTS TO THE STATE HEALTH OFFICER AT THE ADDRESS ABOVE OR TO YOUR LOCAL COUNTY HEALTH OFFICER.**

| CLIENT INFORMATION | |
|---|---|
| First Name: | Middle Initial: |
| Last Name: | |
| Birthdate: ___________/___________/___________ | |
| Sex: ☐ Female ☐ Male | |

☐ Check box if client is an emancipated minor or over 18 years of age.

| PARENT/GUARDIAN INFORMATION |
|---|
| First Name: |
| Last Name: |
| Relationship to Client: |
| Mailing Address: |
| City, State, Zip: |
| Phone: |

| DETERMINATION |
|---|
| Return Determination By: ☐ Mail ☐ I'll Pick Up ☐ Encrypted Email ____________________________________________ |

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### PHYSICIAN'S STATEMENT

A provider may only select vaccines for which a medical contraindication currently exists.

| Vaccine | Medical Contraindication | Temporary (T) or Permanent (P) | Expiration Date (T) |
|---|---|---|---|
| ☐ DTaP/Tdap | | ☐ T ☐ P | |
| ☐ MMR | | ☐ T ☐ P | |
| ☐ Hep B | | ☐ T ☐ P | |
| ☐ Hib | | ☐ T ☐ P | |
| ☐ IPV | | ☐ T ☐ P | |
| ☐ Pneumococcal | | ☐ T ☐ P | |
| ☐ Rotavirus | | ☐ T ☐ P | |
| ☐ Varicella | | ☐ T ☐ P | |

I declare that the physical condition of the above named client is such that vaccination would endanger his/her life or health, or is medically contraindicated due to other medical conditions. I certify that I am a primary health care provider as defined in Wyo. Stat. Ann. § 35-22-40 and that the information provided on this form is complete and accurate.

**Physician First and Last Name (print):** ____________________________________________ **Medical License #:** ______________

**Physician Signature:** ________________________________________ **Date:** __________________

**Additional Physician Notes:** ________________________________________________________________________________

## PARENT/GUARDIAN DECLARATION

I _____________________________________________, request a waiver to the mandatory immunizations identified on the
Printed Name of Parent/Guardian

Physician's Statement for ____________________________________________ due to the existence of a medical contraindication.
Printed Name of Client

I understand that my child may not be allowed to attend a Wyoming child caring facility, head start, preschool or school during a disease outbreak when declared by the State Health Officer or a County Health Officer. I also understand that if this request is approved, it is my responsibility to provide a copy of the approved waiver to the child caring facility, head start, preschool or school. The information I have provided on this form is complete and accurate. I acknowledge that I have read this document in its entirety and fully understand it.

_____________________________________________________________________ ______________________

**Signature of Parent/Guardian** *(Client if emancipated or over 18 years of age)* **Date**

**Notice:** The Wyoming Department of Health uses health information in accordance with the Notice of Privacy Practices found at https://health.wyo.gov/admin/privacy/ and made available upon request.

## NOTARY ACKNOWLEDGEMENT

State of _____________________ County of _______________________

Subscribed and sworn on this _________ day of _______________, 201____, by the above named person

___________________________________________, known by me, or proven to be the person named as the

Parent/Guardian or Client (if emancipated or over 18 years of age) on this Medical Waiver Request.

____________________________________________________
Signature of Notarial Officer

Place Seal or Stamp Here

My commission expires ______________________________.
Expiration Date

## WAIVER DETERMINATION

*(County Health Officer or State Health Officer Use Only)*

☐ **Not Approved*** ☐ **Unable to Process***

* *Reference the included letter for additional information on requests that are not approved or unable to be processed.*

☐ **Approved**, the following mandatory immunization(s) are waived:

__________________________________________________________________________________________

__________________________________________________________ __________________ _____________________

**State Health Officer or County Health Officer Signature** **Date** **County (if applicable)**

**Notice:** If a parent/guardian/client objects to the waiver determination above, a review and final decision by the State Health Officer may be requested in writing.