MEDICAL WAIVER REQUEST

Wyoming Department of Health, Immunization Unit
Attn: Waivers, 6101 Yellowstone Road, Suite 420, Cheyenne, WY 82002
Phone: 307-777-7952 • Fax: 307-777-7996 • Email: wdh-immrecords@wyo.gov

Wyo. Stat. Ann. §§ 21-4-309 and 14-4-116 allow for waivers to the mandatory immunizations required to attend child caring facilities and schools (K-12) based on genuine religious belief or medical contraindication.

Submit requests to the State Health Officer using the information above or to a County Health Officer.

Client Information	Parent/Guardian Information
First Name: Middle Initial:	First Name:
Last Name:	Last Name:
Birthdate: _____/_____/_____	Mailing Address:
Sex: ☐ Female ☐ Male	City, State, Zip:
☐ Emancipated minor or over 18 years of age.	Phone:

If applicable, name of school (K-12): _____
*Waivers are transferrable to any Wyoming school.

Physician's Statement

This section must be completed by a physician licenced in the U.S

Check the box next to the vaccine(s) for which a contraindication[1] exists.

- ☐ Diphtheria, Tetanus and Pertussis (DTaP/Tdap)
- ☐ Haemophilus Influenzae Type B (HIB)
- ☐ Hepatitis B (HepB)
- ☐ Measles, Mumps and Rubella (MMR)
- ☐ Polio (IPV)
- ☐ Pneumococcal (PCV-13)
- ☐ Rotavirus (RV)
- ☐ Varicella (VAR)

**The Advisory Committee on Immunization Practices (ACIP) provides a list of contraindications to commonly used vaccines as well as a list of conditions incorrectly perceived as contraindications in the General Best Practice Guidelines for Immunizations found at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.*

I certify that a condition exists in the client listed above that increases the risk for a serious adverse reaction to the vaccinations indicated. I also certify that I hold a valid medical license in the U.S. and that the information provided on this form is complete and accurate.

Printed Name: _____ **Medical License Number:** _____

Phone Number: _____

Signature: _____ **Date:** _____

Additional Notes: _____

_____

Note: If further information is needed, the State Health Officer, or a County Health Officer may contact you.

[1] Contraindication means a condition in a recipient that increases the risk for a serious adverse reaction to a vaccine.

Client Name: _____ **Date of Birth:** _____/_____/_____

Parent/Guardian Declaration

Per physician recommendation, I am requesting a waiver to the mandatory immunizations for myself or my child to attend a Wyoming preschool, child care facility or school (K-12) due to the existence of a medical contraindication.

I 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.
- My child will not be allowed to attend a child caring facility, head start, preschool or school (K-12) during a vaccine-preventable disease outbreak when declared by the State Health Officer or a County Health Officer.

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 or Emancipated Client **Date**

How would you like the waiver determination returned to you?

☐ Mail ☐ Pick Up ☐ Email: _____

Parent/Guardian Agreement to Release Waiver Determination

If you wish to have the waiver determination sent to a Wyoming school (K-12), please complete the information below.

Name of School: _____ **Attn:** _____

Fax Number: _____ **or Email:** _____

To have a copy of this waiver determination sent to individuals or organizations other than a Wyoming school (K-12), please complete a WDH Authorization to Release Health Records form located at https://health.wyo.gov/admin/privacy/.

Waiver Determination

County Health Officer or State Health Officer Use Only

☐ Not Approved* ☐ Unable to Process* * *Reference the included letter for more information.*

☐ Approved for: _____

_____ _____

Signature of State or County Health Officer **Date**

Notes: _____

_____