MEDICAL VACCINATION EXEMPTION REQUEST FORM

Completion of this form does not guarantee an exemption. Exemptions are rare in great part because vaccines protect not only your teen but also may protect the rest of the community by either herd immunity or limiting the spread of disease. In making these decisions, we must consider the safety of the entire group.

Because of this philosophy and our associated policies, very few exemptions are given. Respectfully, many of the exemptions requested do not have supporting medical data that is an established standard of care and practice. The request for an exemption must contain the medical data supporting the request. There must be a description of what happened, what the treatment was, and how the teen responded/recovered.

If you are requesting an exemption, you must do so within five (5) days of registration. If exemption requests are received after the program cancellation deadline and the exemption is denied, a full refund is not guaranteed.

This form must be completed by the teen's treating licensed physician. Please submit this completed form to the link here: **https://form.jotform.com/252545150646052**

Teen Name _____ Date of Birth _____

BBYO Region _____ Parent Email _____

Healthcare Provider Name _____

ALL PARTICIPANTS WHO ARE IN ATTENDANCE AT BBYO overnight experiences are required to have age-appropriate vaccines recommended by the American Academy of Pediatrics (AAP) and the Center for Disease Control (CDC).

Exemptions to these vaccines will be considered but are not guaranteed. Please indicate which vaccine(s)/number of doses have not been received:

Immunization	Dose 1	Dose 2	Dose 3	Dose 4
Diphtheria, tetanus & acellular pertussis (DTaP)				
Tetanus, diphtheria & acellular pertussis (Tdap)				
IPV (Poliovirus)				

Haemophilus influenzae type B (HIB)				
Pneumococcal conjugate vaccine (PCV)				
Measles, Mumps, Rubella (MMR) or serologic evidence of immunity				
Varicella vaccine (VAR), or serologic or historical evidence of immunity				
Meningococcal disease / Meningitis-ACWY 2 required if 16 years or older				

Vaccine(s) was/were not given due to which of the following reasons:

□ **History of previous severe allergic reaction resulting in respiratory distress.** Please attach supporting medical documentation/description of the reaction and the treatment and recovery from your physician.
□ **History of Guillain-Barre Syndrome within six weeks of receiving a previous vaccine.** Please provide and attach a detailed narrative from your physician that describes the event.
□ **Other**. Please provide this information from your physician in a separate narrative that describes the reason for exemption request in detail. Please note that BBYO does not accept religious exemptions.

I certify that the above-named person has the contraindication noted and I support this request for a medical exemption from vaccination.

Treating Physician Name (print): _____ Date: _____

Treating Physician Signature: _____

Treating Physician Medical License No.: _____

Doctor's Medical Specialization: _____