MEDICAL EXCEPTION to VACCINATION
Johns Hopkins Center for Talented Youth

Please complete the following information and have this form signed by your student's physician. Upload both pages of your completed and signed form to your CampDoc profile in the Immunizations section**.**

Note: In the event of an occurrence of any vaccine-preventable disease, students without documented vaccination or other proof of immunity may be asked to leave the site.

Student Name: _____

Parent Name: _____

Parent E-mail: _____

CTY Student ID: _____

Student Date of Birth: _____/_____/_____

CTY Site Location**:** California ☐ Pennsylvania☐ Maryland ☐ Rhode Island ☐

New York Skidmore College ☐ New York Speyer School ☐

Dear Health Care Provider (MD, NP, DO, PA):

A medical exception to CTY's immunization requirements may be for the reasons listed below. A medical provider must attest that the student is unable to receive the vaccine.

- ☐ Student has specific medical contraindications that make receiving the vaccine inadvisable.
- ☐ Student has begun a vaccine series. However, not enough time will have elapsed since their last dose for them to receive the next dose or a booster before traveling to the program.
- ☐ Student is ineligible for the indicated vaccine or booster according to the vaccine schedule in their country of residence, and there is no provision for children traveling to the United States to receive the vaccine, even at travel vaccination clinics.

Please continue to page 2.

Patient name: _____

The above-named person cannot not receive the indicated vaccine(s). Please check all that apply:

Required Immunizations	**Doses**	**Reason** (see permissable reasons on p. 1. Attach additional information if necessary.)
Tetanus Booster (within 10 years) TT, Td, Tdap, or DTap	Dose 1: ☐	
MMR (2 doses)	All Doses: ☐ Dose 2: ☐	
Measles	All Doses: ☐ Dose 2: ☐	
Mumps	All Doses: ☐ Dose 2: ☐	
Rubella	All Doses: ☐ Dose 2: ☐	
Varicella (2 doses)	All Doses: ☐ Dose 2: ☐	
Hepatitis B. (3 doses, last one on or after 24 weeks of age)	All Doses: ☐ Dose 2: ☐ Dose 3: ☐	
IPV/OPV (Polio) (3-4 doses, with 1 after 4th birthday)	All Doses: ☐ Dose 2:☐ Dose 3: ☐ Dose 4: ☐	
DTaP (3-5 doses)	All Doses: ☐ Dose 2:☐ Dose 3: ☐ Dose 4: ☐ Dose 5: ☐	
Additional Tdap (students in 7th grade or above)	Dose 1: ☐	
NY City (Speyer School) only		
COVID-19	Dose 1: ☐	**Previous infection is not a permissible criterion for an exception.** Describe other reason:
Rhode Island Only (all students)		
Hepatitis A	All Doses: ☐ Dose 2: ☐	
Maryland, New York, Pennsylvania and Rhode Island 7th grade and Above		
Meningococcal	Dose 1: ☐	

I certify that the above-named person cannot receive the indicated vaccine(s) from me or any other health care provider in our country and request exception from the selected doses.

Health Care Provider: _____

Health Care Provider Phone No.: _____

Health Care Provider Medical License No.: _____

Health Care Provider Signature: _____
(Note: ink signature required – no digital or stamps)

Date: _____/_____/_____