DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Immunization Program

Supplemental School Vaccine Medical Exemption Approval Form

DPH Review:

Name of Patient: _____DOB:
Name of Parent/Guardian: _____

_____

Clinician Name:

School:
School Nurse:

Medical exemption(s) Listed:

DPH Review and recommendation: The request for medical exemption is: ☐ Approved ☐ Not Approved

Important note: This approval expires on _____ after which time the child must be brought up to date with the affected vaccine.

_____ Date:

Martin Luta
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Delaware Division of Public Health
Dover, Delaware 19901
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