



# MEDICAL WAIVER REQUEST

Wyoming Department of Health, Immunization Unit  
Attn: Waivers, 122 West 25<sup>th</sup> Street, 3<sup>rd</sup> Floor West, Cheyenne, WY 82002  
Phone: 307-777-7952 • Fax: 307-777-7996 • Email: [wdh.immrecords@wyo.gov](mailto: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 religious belief or medical contraindication.

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

Child's Information		Parent/Guardian Information	
First Name:	Middle Initial:	First Name:	
Last Name:		Last Name:	
Birthdate: ____/____/____		Mailing Address:	
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other		City, State, Zip:	
<input type="checkbox"/> 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<sup>1</sup> exists.

- |  |  |
|--|--|
| <input type="checkbox"/> Diphtheria, Tetanus and Pertussis (DTaP/Tdap) | <input type="checkbox"/> Polio (IPV)           |
| <input type="checkbox"/> Haemophilus Influenzae Type B (HIB)           | <input type="checkbox"/> Pneumococcal (PCV-13) |
| <input type="checkbox"/> Hepatitis B (HepB)                            | <input type="checkbox"/> Rotavirus (RV)        |
| <input type="checkbox"/> Measles, Mumps and Rubella (MMR)              | <input type="checkbox"/> 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:** \_\_\_\_\_ **State Licensed In:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Additional Notes:** \_\_\_\_\_

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

<sup>1</sup> Contraindication means a condition in a recipient that increases the risk for a serious adverse reaction to a vaccine.  
State of Wyoming - Department of Health - Immunization Unit  
Medical Waiver Request (IMM-003)  
Updated: May 2021

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:** \_\_\_\_\_