REQUEST FOR MEDICAL EXCEPTION FROM VACCINATION  
( Including COVID-19 vaccination)  
Johns Hopkins Center for Talented Youth

Please complete the following information and have it signed by your student’s physician.

Upload your completed and signed form here:  
https://hipaacenterfortalentedyouth.formstack.com/forms/vax_exception_request_2023

Student Name:  
________________________________________________________________________

Parent Name:  
________________________________________________________________________

Parent E-mail:  
________________________________________________________________________

CTY Student ID:  
________________________________________________________________________

Student Date of Birth:  __________/________/________

From which vaccine requirement(s) are you seeking a medical exception?

☐ Full vaccination for COVID-19 and up to date with CDC-recommended booster(s).  Note: Having had COVID-19 in the past is NOT a permissible criterion for an exception.

☐ Two doses of MMR (measles, mumps, rubella) OR a titer showing immunity to all three diseases.

☐ Two doses of varicella, or verification of immunity.

☐ A tetanus booster within the last 10 years. This can be any immunization with tetanus—TT, Td, Tdap, or DTaP.

☐ Three to five doses of DTaP.

☐ One additional dose of Tdap if child has completed 7th grade or above. Students in grades 7-12 attending sites in California must have had one dose of pertussis-containing vaccine after age 7.

☐ Three or Four doses IPV/OPV (Polio), with one given after the child’s 4th birthday.

☐ Three doses of Hep B, with last dose on or after 24 weeks of age.

☐ One dose of meningococcal. Required only for students attending CTY sites in Connecticut, Maryland, New York, Pennsylvania, and Rhode Island who have completed 7th grade or above.

☐ Two doses of Hep A, with first dose after first birthday. Required only for students attending CTY sites in Rhode Island and Connecticut.

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

The Center for Talented Youth has vaccine requirements for its student participants. The requirements included being fully vaccinated for COVID and up to date with CDC-recommended COVID booster(s). The above-named person is requesting an exception from one or more of CTY’s vaccination requirements.

Please complete the form below.
COVID-19 Vaccine

A medical exception from COVID-19 vaccination is allowed for certain recognized contraindications.

The above-named person should not be immunized for COVID for the following reasons (please check all that apply):

□ History of previous allergic reaction and documentation to indicate an immediate hypersensitivity reaction to the COVID vaccine or a component of the vaccine. Please attach supporting DOCUMENTATION or MEDICAL RECORDS.

□ Treatment of COVID-19 symptoms with monoclonal antibodies or convalescent plasma within the last 90 days. Please attach supporting DOCUMENTATION or MEDICAL RECORDS.

□ Other – Please provide this information in a separate narrative that describes the exception in detail (these requests will be reviewed on a case-by-case basis). Note: Having had COVID-19 in the past is NOT a permissible criterion for an exception.

Other Vaccines

The above-named person should not be immunized for:

____________________________________________________________________________________

for the following reasons (please check all that apply):

□ History of previous allergic reaction and documentation to indicate an immediate hypersensitivity reaction to the vaccine or a component of the vaccine. Please attach supporting DOCUMENTATION or MEDICAL RECORDS.

□ Other – Please provide this information in a separate narrative that describes the exception in detail (these requests will be reviewed on a case-by-case basis).

I certify that has the above-named person has contraindication(s) and request their medical exception from COVID-19 vaccination and/or other vaccines indicated above.

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: _______/_______/_______

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