

Request for Review of Denied Medical Exemption Request

Date: _____

Parent Name: _____

Address: _____ E-mail Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Child's Name: _____ Date of Birth: ____/____/____

Child's Age: _____ County of School: _____

Date of Immunization Health Officer Exemption Request Denial: _____

Below: Please explain what you feel the State Health Officer should consider as the basis for reversing the decision of the Immunization Health Officer. (Attach additional information as necessary)

Parent Signature: _____ Date: _____
(May be typed for E-mail)

May be sent by **Mail: West Virginia Department of Health and Human Resources
Bureau for Public Health
Attention: State Health Officer
350 Capitol Street Room 702, Charleston, WV 25301**

or **Fax: (304)-558-1035**

or **E-mail: vaccineexemption@wv.gov**