REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION
SCHOOL FORM

INSTRUCTIONS FOR COMPLETION

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1. Fill out the form completely. ALL form fields are required except where noted as being optional.
   a. Enter the name of the Student and other identifying information.
   b. Check off each vaccine for which an exemption is requested.
      i. For each vaccine for which an exemption is requested, check to indicate whether the exemption is **Temporary** (indicate the date through which the exemption is valid) or **Permanent**.
      ii. Check the ACIP contraindication/precaution applicable for each vaccine for which an exemption is requested.
   c. If the contraindication/precaution is not included in Table 1, please put an "X" next to "Other" and fully explain. Please be sure that the contraindication/precaution does not appear in Table 2, that there is a valid contraindication/precaution noted for each vaccine for which an exemption is requested, and that the contraindication/precaution is consistent with ACIP/AAP guidelines and established national standards for vaccination practices.
2. Sign and date the Attestation Statement.
3. Provide a copy to the person requesting the medical exemption or directly to the school, preschool, or child care center.
4. Keep a copy of the form for your records.

Name of Student: *first/middle/last*	Date of Birth:
Name of Parent/Guardian (if under 18): *first/middle/last*	Primary Phone:
Patient/Parent Home Address: *address 1* *address 2* *city* *state* *zip*	
Patient/Parent Email Address:	

Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP), available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html or https://redbook.solutions.aap.org/redbook.aspx

Please check the website to ensure that you are reviewing the most recent ACIP information. Please note that the presence of a moderate to severe acute illness with or without fever is a precaution to administration of all vaccines. However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication.

Table 1. ACIP Contraindications and Precautions to Vaccination for Mandatory Vaccines

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
☐ **DTaP, Tdap**	☐ Temporary through: _____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of a previous dose of DTP, DTaP, or Tdap **Precautions** ☐ Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP or Tdap until neurologic status clarified and stabilized ☐ Guillain-Barré syndrome < 6 weeks after previous dose of tetanus-toxoid-containing vaccine ☐ History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid-containing or tetanus toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus toxoid-containing vaccine
☐ **Inactivated polio virus vaccine (IPV)**	☐ Temporary through: _____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component **Precautions** ☐ Pregnancy
☐ **MMR**	☐ Temporary through: _____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Pregnancy ☐ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with human immunodeficiency virus [HIV] infection who are severely immunocompromised) ☐ Family history of congenital or hereditary immunodeficiency in first-degree relatives (e.g., parents and siblings), unless the immune competence of the potential vaccine recipient has been substantiated clinically or verified by a laboratory test **Precautions** ☐ Recent (≤ 11 months) receipt of antibody-containing blood product (specific interval depends on product) ☐ History of thrombocytopenia or thrombocytopenic purpura ☐ Need for tuberculin skin testing or interferon gamma release assay (IGRA) testing

☐ **Meningococcal (MenACWY)**	☐ Temporary through: _____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component **Precautions** ☐ Preterm Birth (MenACWY-CRM)
☐ **Varicella**	☐ Temporary through: _____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or persons with HIV infection who are severely immunocompromised) ☐ Pregnancy ☐ Family history of congenital or hereditary immunodeficiency in first-degree relatives (e.g., parents and siblings), unless the immune competence of the potential vaccine recipient has been substantiated clinically or verified by a laboratory test **Precautions** ☐ Recent (≤ 11 months) receipt of antibody-containing blood product (specific interval depends on product) ☐ Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination; avoid use of these antiviral drugs for 14 days after vaccination) ☐ Use of aspirin or aspirin-containing products
☐ **Other.** Please explain fully and attach additional sheets as necessary. Please be sure to check Table 2 below to ensure that the condition is not one incorrectly perceived as a contraindication or precaution.		

Attestation

I am a physician (M.D. or D.O) licensed to practice medicine in a jurisdiction of the United States or an advanced practice nurse (N.P./P.A) licensed in a jurisdiction of the United States.

By signing below, I affirm that I have reviewed the current ACIP Contraindications and Precautions and affirm that the stated contraindication(s)/precaution(s) is enumerated by the ACIP and consistent with established national standards for vaccination practices. I understand that I might be required to submit supporting medical documentation. I understand that any misrepresentation will result in referral to the appropriate licensing board and/or regulatory agency.

Healthcare Provider Name *(please print)*:_____ Specialty:_____

NPI Number:_____ License Number:_____ State of Licensure: _____

Practice Name:_____

Phone:_____ Fax:_____

Email:_____

Address:_____ City:_____ State:_____ Zip:_____

Signature:_____ Date:_____

Table 2. Examples of Conditions incorrectly perceived as contraindications or precautions to vaccination* (i.e., vaccines may be given under these conditions)

Vaccine	Conditions incorrectly perceived as contraindications and precautions to vaccines (i.e., vaccines may be given under these conditions)
General for MMR, Hib, HepB, Varicella, PCV13, MenACWY	• History of Guillain-Barré syndrome • Recent exposure to an infectious disease • History of penicillin allergy, other nonvaccine allergies, relatives with allergies, or receiving allergen extract immunotherapy
DTaP	• Fever within 48 hours after vaccination with a previous dose of DTP or DTaP • Collapse or shock like state (i.e., hypotonic hyporesponsive episode) within 48 hours after receiving a previous dose of DTP/DTaP • Seizure ≤ 3 days after receiving a previous dose of DTP/DTaP • Persistent, inconsolable crying lasting ≥ 3 hours within 48 hours after receiving a previous dose of DTP/DTaP • Family history of seizures • Family history of sudden infant death syndrome • Family history of an adverse event after DTP/DTaP • Stable neurologic conditions (e.g., cerebral palsy, well-controlled seizures, or developmental delay)
Hepatitis B (HepB)	• Pregnancy • Autoimmune disease (e.g., systemic lupus erythematosus or rheumatoid arthritis)
Influenza, inactivated injectable (IIV)	• Nonsevere (e.g., contact) allergy to latex, thimerosal, or egg
MMR	• Breastfeeding • Pregnancy of recipient's mother or other close or household contact • Recipient is female of child-bearing age • Immunodeficient family member or household contact • Asymptomatic or mildly symptomatic HIV infection • Allergy to eggs
Tdap	• History of fever of ≥ 40.5° C (≥ 105° F) for < 48 hours after vaccination with previous dose of DTP/DTaP • History of collapse or shock-like state (hypotonic hyporesponsive episode) within 48 hours after receiving a previous dose of DTP/DTaP • History of persistent, inconsolable crying lasting > 3 hours within 48 hours of receiving a previous dose of DTP/DTaP • History of extensive limb swelling after DTP/DTaP/Td that is not an Arthus-type reaction • History of stable neurologic disorder • Immunosuppression
Varicella	• Pregnancy of recipient's mother or other close or household contact • Immunodeficient family member or household contact • Asymptomatic or mildly symptomatic HIV infection • Humoral immunodeficiency (e.g., agammaglobulinemia)

* For a complete list of conditions, please review the ACIP Guide to Contraindications and Precautions accessible at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.