Medical Immunization Exemption Certificate
For Use in Healthcare Facilities

Section 1: Health Care Facility and Worker Information				
NAME OF HEALTH CARE FACILITY	STREET ADDRESS:	CITY	ZIP CODE	PHONE

HEALTH CARE WORKER NAME:	DATE OF BIRTH:

STREET ADDRESS:	CITY:	ZIP CODE	PHONE:

Section 2: For Health Care Provider Use Only: Please provide name, address, vaccine contraindication(s), signature and date.				
NAME OF HEALTH CARE PROVIDER	STREET ADDRESS:	CITY	ZIP CODE	PHONE

I certify that due to the contraindication(s) checked below the above named individual is exempt from receiving the required vaccine(s):

☐ Influenza ☐ Tdap ☐ MMR ☐ Varicella ☐ Hepatitis B

Vaccine	Contraindication(s)	Temporary Contraindications
Influenza , injectable trivalent (TIV)	☐ Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine or to a vaccine component, including egg protein. *A history of Guillain-Barre syndrome within 6 weeks of a previous dose of influenza vaccine is a precaution	
Tdap (tetanus-diphtheria-pertussis)	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Encephalopathy (e.g., coma, decreased level of consciousness, or prolonged seizures) not attributable to another identifiable cause within 7 days of administration of a previous dose of DTP, DTaP, or Tdap *A history of Guillain-Barre syndrome within 6 weeks of a previous dose of Tdap vaccine is a precaution.	☐ Pregnancy (Tdap may be administered after 20 weeks gestation)
MMR (measles-mumps-rubella)	☐ 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 or long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised)	☐ Pregnancy
Varicella	☐ 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 or long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised)	☐ Pregnancy
Hepatitis B	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	

*Vaccine package inserts and CDC recommendations for these vaccines should be consulted for additional information on vaccine-related contraindications and precautions and for more information on vaccine excipients (www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm). Conditions listed as precautions should be reviewed. Benefits of and risks for administering a specific vaccine to a person under these circumstances should be considered. If the risk from the vaccine is believed to outweigh the benefit, the vaccine should not be administered.

_____ _____

Health Care Provider Signature Date

The identifiable information provided by the health care worker to the facility shall not be re-disclosed to any third party without the written authorization of the health care worker, pursuant to the RI Confidentiality Health care Information Act, RI General Laws chapter 5-37.1. Do not send a copy of this form to the Department of Health. Only non-identifying information aggregated by the facility shall be reported to the RI Department of health for statistical purposes.