Medical Immunization Exemption Certificate For Use in Healthcare Facilities

Section 1: Healthcare Facility and Worker Information				
Name of Healthcare Facility	Street Address	City	Zip Code	Phone
Healthcare Worker Name		Date of Birth		
Street Address	City	Zip Code	Phone	

Section 2: For Healthcare Provider Use Only - Provide name, address, vaccine contraindication(s), signature, and date				
Name of Healthcare Provider	Street Address	City	Zip Code	Phone

1. I certify that due to the contraindication(s) checked below the above named individual is exempt from receiving the required vaccine(s).
2. The contraindication(s) marked below is in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines, American Academy of Pediatrics (AAP) guidelines, or vaccine package insert instructions: (Check where applicable)

☐ Influenza ☐ MMR ☐ Varicella ☐ Tdap ☐ Hepatitis B

Contraindications	Precautions or Temporary Contraindications
☐ Serious allergic reaction (e.g., anaphylaxis) after a previous vaccine dose. (General for all vaccines) ☐ Serious allergic reaction (e.g., anaphylaxis) to a vaccine component. (General for all vaccines) ☐Influenza - severe allergic reaction to egg protein (Injectable and LAIV) ☐ Influenza (LAIV) - Pregnancy, Immunosuppression, certain chronic medical conditions* ☐ MMR – contraindicated with immunodeficiency, due to any cause, including HIV ☐ Varicella – contraindicated with substantial suppression of cellular immunity, including severely immunocompromised with HIV.	☐ Moderate or severe acute illness with or without fever ☐ Recent administration of an antibody-containing blood product (MMR, Varicella) ☐ Pregnancy - (MMR, Varicella) ☐ Guillain-Barre syndrome history within 6 weeks after a previous dose (tetanus toxoid-containing vaccine, Influenza vaccine). ☐ LAIV Flu Vaccine – receipt of specific antivirals 48 hours before vaccination (i.e., amantadine, rimantadine, zanamivir or oseltamivir). Avoid use of these antivirals until 14 days after vaccination.
☐Tdap - Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP, DTaP or Tdap. .	☐Tdap - History of arthus-type hypersensitivity reactions after a previous dose of tetanus toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid containing vaccine. ☐ Tdap - Progressive or unstable neurologic disorders, defer Tdap vaccination until a treatment regimen has been established and the condition has stabilized.

*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.

______________________________ Healthcare 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 Rhode Island Department of Health. Only non-identifying information aggregated by the facility shall be reported to the RI Department of health for statistical purposes.