



Wellness Center

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Vaccine Medical Exemption Request Form

A student may be exempted from one or more of the specific immunization requirements by written statement by a provider indicating the nature and probable duration of the medical condition or circumstances that contraindicates those immunizations, identifying the specific vaccines that could be detrimental to the student's health. Illinois College Immunization Code: Section 694.200 Medical Exemption
<https://ilga.gov/commission/icar/admincode/077/077006940C02000R.html>

Section I: Should be completed by student or guardian (if student is under 18 years old)

Name of Student: _____ Student ID #: _____ Date of Birth: _____
First/Middle/Last

Name of Parent/Guardian (if under 18): _____

Primary Home Address: _____

Student Email Address: _____ Primary Phone: _____

Signature: _____ Date: _____
Student or guardian if under 18

Section II: Should be completed by medical provider

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>. Please check the website to ensure that you are reviewing the most recent ACIP information. Please note that the presence of a sore arm, local reaction, and moderate to severe acute illness with or without fever are possible after administration of all vaccines. However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication. Please review the ACIP Guide to confirm that any noted condition is not commonly misperceived as a contraindication or precaution in the above ACIP link.

Table 1. ACIP Contraindications and Precautions to Vaccination

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
<input type="checkbox"/> DTaP, Tdap <input type="checkbox"/> DT, Td	<input type="checkbox"/> Temporary through: _____ <input type="checkbox"/> Permanent	Contraindications <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> 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 or DTP, DTaP, or Tdap <input type="checkbox"/> Other: Explain fully below Precautions <input type="checkbox"/> Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP or Tdap until neurologic status clarified and stabilized <input type="checkbox"/> Guillan-Barre (GBS) within 6 weeks after previous dose of tetanus-toxoid containing vaccine <input type="checkbox"/> History of Arthus-type hypersensitivity reaction following a previous dose of tetanus and/or diphtheria toxoid-containing vaccine: defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid containing vaccine <input type="checkbox"/> Moderate or severe acute illness with or without fever
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Temporary through: _____ <input type="checkbox"/> Permanent	Contraindications <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Hypersensitivity to yeast <input type="checkbox"/> Other: Explain fully below Precautions <input type="checkbox"/> Moderate or severe acute illness with or without fever
<input type="checkbox"/> Influenza, Inactivated injectable (IIV)	<input type="checkbox"/> Temporary through: _____ <input type="checkbox"/> Permanent	Contraindications <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Other: Explain fully below Precautions <input type="checkbox"/> Guillan-Barre (GBS) within 6 weeks after previous dose of influenza vaccine <input type="checkbox"/> Moderate or severe acute illness with or without fever <input type="checkbox"/> Egg allergy other than hives, e.g., angioedema, respiratory distress, lightheadedness, recurrent emesis; or required epinephrine or another emergency medical intervention

		<i>IIV may be administered in an inpatient or outpatient medical setting and under the supervision of a health care provider who is able to recognize and manage severe allergic conditions</i>
<input type="checkbox"/> MMR (Measles, Mumps, Rubella)	<input type="checkbox"/> Temporary through: _____ <input type="checkbox"/> Permanent	Contraindications <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Pregnancy Estimated Date of Confinement (EDC) _____ (month, day, year) <input type="checkbox"/> Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) <input type="checkbox"/> Family history of altered immunocompetence <input type="checkbox"/> Other: Explain fully below Precautions <input type="checkbox"/> Recent (< 11 months) receipt of antibody-containing blood products (specific interval depends on product) <input type="checkbox"/> History of thrombocytopenia or thrombocytopenic purpura <input type="checkbox"/> Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing <input type="checkbox"/> Moderate or severe acute illness with or without fever
<input type="checkbox"/> Meningococcal (MenACWY)	<input type="checkbox"/> Temporary through: _____ <input type="checkbox"/> Permanent	Contraindications <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component including yeast <input type="checkbox"/> Other: Explain fully below Precautions <input type="checkbox"/> Moderate or severe acute illness with or without fever <input type="checkbox"/> Preterm birth (MenACWY-CRM)
<input type="checkbox"/> Varicella	<input type="checkbox"/> Temporary through: _____ <input type="checkbox"/> Permanent	Contraindications <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) <input type="checkbox"/> Pregnancy Estimated Date of Confinement (EDC) _____ (month, day, year) <input type="checkbox"/> Family history of altered immunocompetence <input type="checkbox"/> Other: Explain fully below Precautions <input type="checkbox"/> Recent (< 11 months) receipt of antibody-containing blood products (specific interval depends on product) <input type="checkbox"/> Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (void use of these antiviral drugs for 14 days after vaccination) <input type="checkbox"/> Use of aspirin or aspirin-containing products <input type="checkbox"/> Moderate or severe acute illness with or without fever

Other: Please explain fully the nature and probable duration of the medical condition or circumstances that contraindicate those immunizations, identifying the specific vaccines that could be detrimental to the student's health. Attach additional sheets as necessary.

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 provider (nurse practitioner or physician's assistant) 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) pose a concern or could be detrimental to the student's health.

Healthcare Provider Name (please print): _____

Signature: _____ Date: _____

State of Licensure: _____ NPI Number: _____