### **Student Medical Exemption Certificate for Required Immunizations**

Name of Primary Care Provider granting exemption:	
Please check one (practitioner granting exemption mu	st be licensed as one of the following):
🗌 Physician (MD or DO) 🗌 Physician Assistant	□ APRN
CT License number:	
<u>NPI:</u>	
Phone number:	Email:

#### **Directions:**

Part 1. Please complete the demographics section on the patient/student.

**Part 2.** Please mark the contraindications/precautions that apply to this patient/student (indicate all that apply).

**Part 3**. If no contraindications or precautions apply in part 2, write a brief explanation of the reason the patient/student requires the exemption.

Part 4. Sign the Statement of Clinical Opinion and date the form.

Attach a copy of the patient/student's most current immunization record.

#### Part 1. Patient/Student Information:

First name <u> (in full)</u>	Middle initial	Last name	
Date of Birth			
Mailing Address	City		
State			
Parent/Guardian: First Name			
Primary phone number			
School name			
School address			
City			
State	Zip		
Current or Grade student is entering			

**Part 2.** Please mark the vaccine(s), exemption duration, and all contraindications/precautions that apply to this patient/student for each vaccine.

Medical contraindications and precautions for immunizations are based upon the Advisory Committee on Immunization Practices (ACIP) <u>Comprehensive General Recommendations and Guidelines</u>, published by the Centers for Disease Control and Prevention.

A **contraindication** is a condition in a recipient that increases the risk for a serious vaccine adverse event (VAE) or compromises the ability of the vaccine to produce immunity.

A **precaution** is a condition in a recipient that might increase the risk for a serious VAE or that might compromise the ability of the vaccine to produce immunity. Under normal conditions, vaccinations are deferred when a precaution is self-limiting, but can be administered if the precaution condition improves.

Vaccine	Exemption Duration	ACIP Contraindications and Precautions (Check all that apply)
□ Diphtheria- Tetanus-and acellular Pertussis (DT-D)	Temporary	Contraindications
	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	
	mm/ yyyy	Encephalopathy within seven days after receipt of previous dose
(DTaP)	Permanent	of DTP or DTaP
		Precautions
		Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy: defer DTaP until neurologic status clarified and stabilized
		<ul> <li>GBS &lt;6 weeks after previous dose of tetanus-toxoid–containing vaccine</li> </ul>
		Fever greater than 40.5°C (104.9°F) <48 hours after vaccination of previous dose of DTP or DTaP
		<ul> <li>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</li> </ul>
		Moderate or acute illness with or without fever
Hepatitis A	Temporary	Contraindications
through: / mm/ yyyy □ Permanent	□ Severe allergic reaction (e.g., anaphylaxis) after a previous dose	
	/	or to a vaccine component
	_	Precautions
	□ Permanent	Moderate or severe acute illness with or without fever

# **CDC Recognized Contraindications and Precautions**

-	Temporary	Contraindications
	through:	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
	mm/ yyyy	Hypersensitivity to yeast
	Permanent	Precautions
		Moderate or severe acute illness with or without fever
□Haemophilus		Contraindications
<i>influenza</i> e type b (HiB)		Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
	mm/ yyyy	□ Age <6 weeks
	Permanent	Precautions
		Moderate or severe acute illness with or without fever
□ Inactivated	□ Temporary through: / mm/ yyyy □ Permanent	Contraindications
Influenza Virus (IIV)		Severe allergic reaction (e.g., anaphylaxis) after previous dose of influenza vaccine or to vaccine component
		Precautions
		□ GBS <6 weeks after a previous dose of influenza vaccine
		Moderate or severe acute illness with or without fever
		Egg allergy other than hives, e.g., angioedema, respiratory distress, lightheadedness, recurrent emesis; or required epinephrine or another emergency medical intervention (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).
<ul> <li>Inactivated</li> <li>Polio Vaccine</li> <li>(IPV)</li> </ul>	□ Temporary through: / mm/ yyyy □ Permanent	Contraindications
		Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
		Precautions
		Pregnancy
		Moderate or acute illness with or without fever

Attenuated Influenza Virus (LAIV) mm/ y	Temporary through:/	Contraindications
		Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
	mm∕ yyyy □ Permanent	<ul> <li>Concomitant use of aspirin or aspirin-containing medication in children and adolescents</li> </ul>
		<ul> <li>LAIV4 should not be administered to persons who have taken oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days.(e)</li> </ul>
		Pregnancy
		Children aged 2 through 4 years who have received a diagnosis of asthma or whose parents or caregivers report that a health care provider has told them during the preceding 12 months that their child had wheezing or asthma or whose medical record indicates a wheezing episode has occurred during the preceding 12 months.
		<ul> <li>Persons with active cerebrospinal fluid/oropharyngeal communications/leaks.</li> </ul>
		Close contacts and caregivers of severely immunosuppressed persons who require a protected environment.
		<ul> <li>Persons with cochlear implants (due to the potential for CSF leak, which might exist for some period of time after implantation.</li> <li>Providers might consider consultation with a specialist concerning risk of persistent CSF leak if an age-appropriate inactivated or recombinant vaccine cannot be used).</li> </ul>
		Altered Immunocompetence
		□ Anatomic or functional asplenia (e.g. sickle cell disease)
		Precautions
		□ GBS <6 weeks after a previous dose of influenza vaccine
		Asthma in persons aged 5 years old or older
		<ul> <li>Medical conditions which might predispose to higher risk of complications attributable to influenza(d)</li> </ul>
		Moderate or severe acute illness with or without fever
🗆 Meningo-	□ Temporary through: / mm/ yyyy	Contraindications
coccal conjugate		Severe allergic reaction (e.g., anaphylaxis) after a previous dose
vaccines (MenACWY)		or to a vaccine component, including yeast Precautions
	Permanent	Moderate or severe acute illness with or without fever

Measles-	Temporary	Contraindications
Mumps-Rubella (MMR)	through: /	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
	mm/ yyyy	Pregnancy
	Permanent	Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy (i) or patients with HIV infection who are severely immunocompromised)
		□ Family history of altered immunocompetence (i)
		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 (k)
		Moderate or severe acute illness with or without fever
🗆 Pneumo-	Temporary	Contraindications
	through: / mm/ yyyy	Severe allergic reaction (e.g., anaphylaxis) after a previous dose of PCV13 or any diphtheria-toxoid–containing vaccine or to a component of a vaccine (PCV13 or any diphtheria-toxoid– containing vaccine), including yeast
		Precautions
		Moderate or acute illness with or without fever
□ Tdap	□ Temporary through: / mm/ yyyy □ Permanent	Contraindications
		Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
		<ul> <li>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</li> </ul>
		Precautions
		□ GBS <6 weeks after a previous dose of tetanus-toxoid–containing vaccine
		Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized
		□ History of Arthus-type hypersensitivity reactions after a previous

		<ul> <li>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</li> <li>Moderate or severe acute illness with or without fever</li> </ul>
Varicella	Varicella 🛛 Temporary	Contraindications
through: / mm/ yyyy □ Permanent	/	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 (i) or patients with HIV infection who are severely immunocompromised) (g)
		Pregnancy
		□ Family history of altered immunocompetence (j)
		Precautions
		<ul> <li>Recent (&lt;11 months) receipt of antibody-containing blood product (specific interval depends on product)</li> </ul>
		$\Box$ Moderate or acute illness with or without fever

### Part 3. Other Allergic Reactions/ Other Type of Medical Condition

Complete this section if claiming a medical exemption for a vaccine based on a condition that does NOT meet any of the ACIP criteria for a contraindication or precaution listed in part 2.

Vaccine(s), list all that apply:

For each vaccine listed above, select the allergic or other reaction for which medical exemption is being submitted. Please check off any of the following that apply:

- □ This patient has an autoimmune disorder
- $\hfill\square$  This patient has a family history of an autoimmune disorder
- □ This patient has a family history of a reaction to a vaccination
- □ This patient has a genetic predisposition to a reaction to a vaccination as determined through genetic testing
- □ This patient has a previous documented reaction that is correlated to a vaccination
- Other condition/reaction not listed above (must specify): \_\_\_\_\_\_

Please provide an explanation of the reaction/condition listed above:

# Part 4. Statement of Clinical Opinion

In accord with the legal requirements of Public Act 21-6, the vaccine(s) indicated above is/are in my clinical opinion medically contraindicated for this patient/student due to the physical condition as explained above.

Clinician's Signature\_\_\_\_\_

Date \_\_\_\_\_

A person may be placed into quarantine or isolation when there are "reasonable grounds to believe [a person] to be infected with, or exposed to, a communicable disease or to be contaminated or exposed to contamination or at reasonable risk of having a communicable disease or being contaminated or passing such communicable disease or contamination to other persons if the commissioner determines that such individual or individuals pose a significant threat to the public health and that quarantine or isolation is necessary and the least restrictive alternative to protect or preserve the public health." <u>Conn. Gen. Stat.</u> § 19a-131b(a).