

# Seton Hall University Health Services

## REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION

Name of Student: <small>first / middle / last</small>	Date of Birth:
Name of Parent/Guardian (if under 18): <small>first / middle / last</small>	Primary Phone:
Patient/Parent Home Address: <small>address 1</small> <span style="margin-left: 150px;"><small>address 2</small></span> <span style="margin-left: 150px;"><small>city</small></span> <span style="margin-left: 100px;"><small>state</small></span> <span style="margin-left: 20px;"><small>zip</small></span>	
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)
<input type="checkbox"/> <b>DTaP, Tdap</b>	<input type="checkbox"/> Temporary through: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <input type="checkbox"/> Permanent	<div style="background-color: #ffe0b2; padding: 2px; margin-bottom: 5px;"><b>Contraindications</b></div> <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 of DTP, DTaP, or Tdap <div style="background-color: #fff9c4; padding: 2px; margin-top: 5px;"><b>Precautions</b></div> <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"/> Guillain-Barré syndrome < 6 weeks after previous dose of tetanus-toxoid-containing vaccine <input type="checkbox"/> 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
<input type="checkbox"/> <b>DT, Td</b>	<input type="checkbox"/> Temporary through: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <input type="checkbox"/> Permanent	<div style="background-color: #ffe0b2; padding: 2px; margin-bottom: 5px;"><b>Contraindications</b></div> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <div style="background-color: #fff9c4; padding: 2px; margin-top: 5px;"><b>Precautions</b></div> <input type="checkbox"/> Guillain-Barré syndrome < 6 weeks after a previous dose of tetanus-toxoid-containing vaccine. <input type="checkbox"/> History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria- or tetanus toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid-containing vaccine

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Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
<input type="checkbox"/> Haemophilus influenzae type b (Hib)	<input type="checkbox"/> Temporary through: <input type="text"/> <input type="checkbox"/> Permanent	<b>Contraindications</b> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
<input type="checkbox"/> Hepatitis B (HepB)	<input type="checkbox"/> Temporary through: <input type="text"/> <input type="checkbox"/> Permanent	<b>Contraindications</b> <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"/> Inactivated poliovirus vaccine (IPV)	<input type="checkbox"/> Temporary through: <input type="text"/> <input type="checkbox"/> Permanent	<b>Contraindications</b> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <b>Precautions</b> <input type="checkbox"/> Pregnancy
<input type="checkbox"/> Influenza, inactivated injectable (IIV)	<input type="checkbox"/> Temporary through: <input type="text"/> <input type="checkbox"/> Permanent	<b>Contraindications</b> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after previous dose of influenza vaccine or to vaccine component <b>Precautions</b> <input type="checkbox"/> Guillain-Barré syndrome < 6 weeks after a previous dose of influenza vaccine <input type="checkbox"/> Egg allergy other than hives, e.g., angioedema, respiratory distress, lightheadedness, or recurrent emesis; or required epinephrine or another emergency medical intervention (IIV may be administered in an inpatient or outpatient medical setting, under the supervision of a healthcare provider who is able to recognize and manage severe allergic conditions)
<input type="checkbox"/> Influenza, recombinant (RIV)	<input type="checkbox"/> Temporary through: <input type="text"/> <input type="checkbox"/> Permanent	<b>Contraindications</b> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) to any component of the vaccine <b>Precautions</b> <input type="checkbox"/> Guillain-Barré syndrome < 6 weeks after a previous dose of influenza vaccine

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Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
<input type="checkbox"/> <b>MMR</b>	<input type="checkbox"/> Temporary through: <input type="text"/> <input type="checkbox"/> Permanent	<p><b>Contraindications</b></p> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Pregnancy <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 human immunodeficiency virus [HIV] infection who are severely immunocompromised) <input type="checkbox"/> 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
<input type="checkbox"/> <b>Meningococcal (MenACWY)</b>	<input type="checkbox"/> Temporary through: <input type="text"/> <input type="checkbox"/> Permanent	<p><b>Contraindications</b></p> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
<input type="checkbox"/> <b>Meningococcal (MenB)</b>	<input type="checkbox"/> Temporary through: <input type="text"/> <input type="checkbox"/> Permanent	<p><b>Contraindications</b></p> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
<input type="checkbox"/> <b>Pneumococcal (PCV13)</b>	<input type="checkbox"/> Temporary through: <input type="text"/> <input type="checkbox"/> Permanent	<p><b>Contraindications</b></p> <input type="checkbox"/> 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

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Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
<input type="checkbox"/> <b>Varicella</b>	<input type="checkbox"/> Temporary through: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <input type="checkbox"/> Permanent	<p><b>Contraindications</b></p> <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 persons with HIV infection who are severely immunocompromised) <input type="checkbox"/> Pregnancy <input type="checkbox"/> 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 <p><b>Precautions</b></p> <input type="checkbox"/> Recent ( $\leq 11$ months) receipt of antibody-containing blood product (specific interval depends on product) <input type="checkbox"/> 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 <input type="checkbox"/> Use of aspirin or aspirin-containing products
<input type="checkbox"/> <b>COVID-19</b>	<input type="checkbox"/> Temporary Through <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> <input type="checkbox"/> Permanent	<p><b>Contraindications</b></p> <input type="checkbox"/> Severe allergic reaction after a previous dose or to a vaccine component
<p>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.</p>		

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**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 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 also understand that any misrepresentation might result in referral to the New Jersey State Board of Medical Examiners and/or appropriate licensing/regulatory agency.

Healthcare Provider Name (please print): \_\_\_\_\_ Specialty: \_\_\_\_\_

NPI Number: \_\_\_\_\_ License Number: \_\_\_\_\_ State of Licensure: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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<b>Table 2. Examples of Conditions incorrectly perceived as contraindications or precautions to vaccination* (i.e., vaccines may be given under these conditions)</b>	
<b>Vaccine</b>	<b>Conditions incorrectly perceived as contraindications and precautions to vaccines (i.e., vaccines may be given under these conditions)</b>
<b>General for MMR, Hib, HepB, Varicella, PCV13, MenACWY</b>	<ul style="list-style-type: none"> <li>• History of Guillain-Barré syndrome</li> <li>• Recent exposure to an infectious disease</li> <li>• History of penicillin allergy, other nonvaccine allergies, relatives with allergies, or receiving allergen extract immunotherapy</li> </ul>
<b>DTaP</b>	<ul style="list-style-type: none"> <li>• Fever within 48 hours after vaccination with a previous dose of DTP or DTaP</li> <li>• Collapse or shock like state (i.e., hypotonic hyporesponsive episode) within 48 hours after receiving a previous dose of DTP/DTaP</li> <li>• Seizure ≤ 3 days after receiving a previous dose of DTP/DTaP</li> <li>• Persistent, inconsolable crying lasting ≥ 3 hours within 48 hours after receiving a previous dose of DTP/DTaP</li> <li>• Family history of seizures</li> <li>• Family history of sudden infant death syndrome</li> <li>• Family history of an adverse event after DTP/DTaP</li> <li>• Stable neurologic conditions (e.g., cerebral palsy, well-controlled seizures, or developmental delay)</li> </ul>
<b>Hepatitis B (HepB)</b>	<ul style="list-style-type: none"> <li>• Pregnancy</li> <li>• Autoimmune disease (e.g., systemic lupus erythematosus or rheumatoid arthritis)</li> </ul>
<b>Influenza, inactivated injectable (IIV)</b>	<ul style="list-style-type: none"> <li>• Nonsevere (e.g., contact) allergy to latex, thimerosal, or egg</li> </ul>
<b>MMR</b>	<ul style="list-style-type: none"> <li>• Breastfeeding</li> <li>• Pregnancy of recipient's mother or other close or household contact</li> <li>• Recipient is female of child-bearing age</li> <li>• Immunodeficient family member or household contact</li> <li>• Asymptomatic or mildly symptomatic HIV infection</li> <li>• Allergy to eggs</li> </ul>
<b>Tdap</b>	<ul style="list-style-type: none"> <li>• History of fever of ≥ 40.5° C (≥ 105° F) for &lt; 48 hours after vaccination with previous dose of DTP/DTaP</li> <li>• History of collapse or shock-like state (hypotonic hyporesponsive episode) within 48 hours after receiving a previous dose of DTP/DTaP</li> <li>• History of persistent, inconsolable crying lasting &gt; 3 hours within 48 hours of receiving a previous dose of DTP/DTaP</li> <li>• History of extensive limb swelling after DTP/DTaP/Td that is not an Arthus-type reaction</li> <li>• History of stable neurologic disorder</li> <li>• Immunosuppression</li> </ul>
<b>Varicella</b>	<ul style="list-style-type: none"> <li>• Pregnancy of recipient's mother or other close or household contact</li> <li>• Immunodeficient family member or household contact</li> <li>• Asymptomatic or mildly symptomatic HIV infection</li> <li>• Humoral immunodeficiency (e.g., agammaglobulinemia)</li> </ul>

\* 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>.