New Jersey Department of Health Vaccine Preventable Disease Program

REQUEST FOR MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION

Name:	**Date of Birth:**
ID#:	**Phone #:**
HMH Facility:	**Department:**
E-Mail Address:	**Chair/Leader:**

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/mmwr/volumes/69/rr/rr6908a1.htm?s_cid=rr6908a1_e&deliveryName=USCDC_921-DM35682#T2_down 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.

ACIP Contraindications and Precautions to Vaccination for Mandatory Vaccines

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
Influenza, inactivated injectable (IIV)	Temporary through:	**Contraindications** Severe allergic reaction (e.g., anaphylaxis) after previous dose of influenza vaccine or to vaccine component **Precautions** Guillain-Barré syndrome < 6 weeks after a previous dose of influenza vaccine
	Permanent	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)
Influenza, Recombinant (RIV)	Temporary through:	**Contraindications** Severe allergic reaction (e.g., anaphylaxis) to any component of the vaccine **Precautions**
	Permanent	Guillain-Barré syndrome < 6 weeks after a previous dose of influenza vaccine

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 it is my opinion, based on my medical assessment, that this individual has a medical contraindication to influenza vaccination. 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: ____________________________________

PLEASE SIGN/DATE BELOW. PLEASE NOTE – SIGNATURE STAMP IS NOT ACCEPTABLE

Signature: ____ Date: ___________________

ATTN: TM, LIP, VOLUNTEER - PLEASE FAX THIS COMPLETED FORM BY NOVEMBER 2, 2020
TO YOUR REGIONAL OH OFFICE AT THE FAX NUMBER PROVIDED BELOW

NORTH REGION: 551-996-4622 **CENTRAL REGION/CORPORATE:** 732-318-3898 **SOUTH REGION:** 848-994-7420