VACCINE MEDICAL EXEMPTION

State Form 54648 (4-11)
Indiana State Department of Health, Immunization Division

INSTRUCTIONS: *1. This form for any child in grades K – 12 who is unable to receive a vaccine required for school entry due to a medical contraindication.*
2. Complete and sign form. Submitted to school as proof of exemption from required immunization.

Patient Name _____ Date of Birth *(month/day/year)* _____

Parent/Guardian Name _____ Relationship _____

Street Address _____

City _____ ZIP Code _____ Telephone Number _____

General Contraindications to All Vaccines (*Vaccine should **not** be given.*)

Severe allergic reaction (e.g., anaphylaxis) after a previous vaccine dose or to a vaccine component

- ☐ Hepatitis B (Hep B)
- ☐ Diphtheria, tetanus, pertussis (DTaP, Tdap)
- ☐ Tetanus, diphtheria (DT, Td)
- ☐ Inactivated poliovirus (IPV)
- ☐ Measles, mumps, rubella (MMR)
- ☐ Varicella (Var)
- ☐ Meningococcal, conjugate (MCV4) or Meningococcal, polysaccharide (MPSV4)

Which vaccine or vaccine component caused reaction? _____

Type of Clinical Reaction & Date *(month, day year)* _____

Vaccine Specific Contraindications (Vaccine should **not** be given.)

DTaP or Tdap	☐ Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within seven (7) days of administration of previous dose of DTP or DTaP
MMR	☐ Pregnancy Estimated Date of Confinement (EDC): _____ *(month, day year)* ☐ Known severe immunodeficiency (e.g., hematologic and solid tumors; receiving chemotherapy; congenital immunodeficiency; long term immunosuppressive therapy; or patients with HIV infection who are severely immunocompromised)
Varicella	☐ Pregnancy Estimated Date of Confinement (EDC): _____ *(month, day year)* ☐ Substantial suppression of cellular immunity

Vaccine Specific Precautions (*Vaccine may be given or held depending on clinical situation.*)

DTaP or Tdap	☐ Guillan-Barre syndrome (GBS) within six (6) weeks after a previous dose of tetanus-containing vaccine ☐ History of Arthus-type hypersensitivity reaction following a previous dose of tetanus and/or diphtheria toxoid-containing vaccine: defer vaccination until at least ten (10) years have elapsed since the previous dose ☐ Progressive or unstable neurologic disorder, uncontrolled seizures or progressive encephalopathy: defer vaccination with DTaP or Tdap until a treatment regiment has been established and the condition has stabilized
DTaP	☐ Temperature of ≥105F (≥40.5C) within forty-eight (48) hours after vaccination with a previous dose of DTP/DTaP ☐ Collapse and shock-like state (i.e.: hypotonic hyporesponsive episode) within forty-eight (48) hours after previous dose of DTP/DTaP ☐ Seizure or convulsion within three (3) days after receiving a previous dose of DTP/DTaP ☐ Persistent, inconsolable crying lasting three (3) or more hours within forty-eight (48) hours after a previous dose of DTP/DTaP
MMR	☐ Recent (within eleven (11) months) receipt of antibody-containing blood product (interval depends on product) ☐ History of thrombocytopenia or thrombocytopenic purpura
Varicella	☐ Recent (within eleven (11) months) receipt of antibody-containing blood product (interval depends on product) ☐ Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) twenty-four (24) hours before vaccination; if possible, delay resumption of these antiviral drugs for fourteen (14) days after vaccination

Other Medical Contraindication (*Must list vaccine(s) and contraindications individually – continue on back if necessary.*)

Vaccine	Specific Contraindication

Please indicate the duration of the medical exemption, and if and when vaccine can be safely administered.
(Exemption can last for a maximum of one (1) year, and a new form must be completed annually if medical exemption still applies.)

- ☐ Medical exemption is permanent, and will apply for one (1) year from today's date.
- ☐ Medical exemption is temporary (<1 year), and resolution is anticipated by ____/____/____
- ☐ Medical exemption is pregnancy, and Estimated Date of Confinement (EDC) is ____/____/____

Physician Name _____ Physician License Number _____

Office Address _____ Telephone _____

Physician Signature _____ Date *(month, day year)* _____