

## Student Medical Exemption Certificate for Required Immunizations

Name of Primary Care Provider granting exemption: \_\_\_\_\_

Please check one (practitioner granting exemption must be licensed as one of the following):

Physician (MD or DO)     Physician Assistant     APRN

CT License number: \_\_\_\_\_

NPI: \_\_\_\_\_

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 (in full) \_\_\_\_\_ Middle initial \_\_\_\_\_ Last name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian: First Name \_\_\_\_\_ Last 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) [Comprehensive General Recommendations and Guidelines](#), 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.

### CDC Recognized Contraindications and Precautions

| Vaccine   | Exemption Duration  | ACIP Contraindications and Precautions (Check all that apply)   |
|---|---|---|
| <input type="checkbox"/> <b>Diphtheria-Tetanus-and acellular Pertussis (DTaP)</b> | <input type="checkbox"/> <b>Temporary through:</b><br>____/____<br><b>mm/ yyyy</b><br><input type="checkbox"/> <b>Permanent</b> | <p><b>Contraindications</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component</li> <li><input type="checkbox"/> Encephalopathy within seven days after receipt of previous dose of DTP or DTaP</li> </ul> <p><b>Precautions</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy: defer DTaP until neurologic status clarified and stabilized</li> <li><input type="checkbox"/> GBS &lt;6 weeks after previous dose of tetanus-toxoid-containing vaccine</li> <li><input type="checkbox"/> Fever greater than 40.5°C (104.9°F) &lt;48 hours after vaccination of previous dose of DTP or DTaP</li> <li><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</li> <li><input type="checkbox"/> Moderate or acute illness with or without fever</li> </ul> |
| <input type="checkbox"/> <b>Hepatitis A</b>                                       | <input type="checkbox"/> <b>Temporary through:</b><br>____/____<br><b>mm/ yyyy</b><br><input type="checkbox"/> <b>Permanent</b> | <p><b>Contraindications</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component</li> </ul> <p><b>Precautions</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Moderate or severe acute illness with or without fever</li> </ul>   |

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|---|--|--|
| <input type="checkbox"/> Hepatitis B                                | <input type="checkbox"/> Temporary through:<br>____/____<br>mm/ yyyy<br><input type="checkbox"/> Permanent | <b>Contraindications</b><br><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component<br><input type="checkbox"/> Hypersensitivity to yeast<br><b>Precautions</b><br><input type="checkbox"/> Moderate or severe acute illness with or without fever   |
| <input type="checkbox"/> <i>Haemophilus influenzae</i> type b (HiB) | <input type="checkbox"/> Temporary through:<br>____/____<br>mm/ yyyy<br><input type="checkbox"/> Permanent | <b>Contraindications</b><br><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component<br><input type="checkbox"/> Age <6 weeks<br><b>Precautions</b><br><input type="checkbox"/> Moderate or severe acute illness with or without fever  |
| <input type="checkbox"/> Inactivated Influenza Virus (IIV)          | <input type="checkbox"/> Temporary through:<br>____/____<br>mm/ yyyy<br><input type="checkbox"/> Permanent | <b>Contraindications</b><br><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after previous dose of influenza vaccine or to vaccine component<br><b>Precautions</b><br><input type="checkbox"/> GBS <6 weeks after a previous dose of influenza vaccine<br><input type="checkbox"/> Moderate or severe acute illness with or without fever<br><input type="checkbox"/> 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). |
| <input type="checkbox"/> Inactivated Polio Vaccine (IPV)            | <input type="checkbox"/> Temporary through:<br>____/____<br>mm/ yyyy<br><input type="checkbox"/> Permanent | <b>Contraindications</b><br><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component<br><b>Precautions</b><br><input type="checkbox"/> Pregnancy<br><input type="checkbox"/> Moderate or acute illness with or without fever  |

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|---|---|---|
| <input type="checkbox"/> Live Attenuated Influenza Virus (LAIV)     | <input type="checkbox"/> Temporary through: _____/_____<br>mm/ yyyy<br><input type="checkbox"/> Permanent | <p><b>Contraindications</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component</li> <li><input type="checkbox"/> Concomitant use of aspirin or aspirin-containing medication in children and adolescents</li> <li><input type="checkbox"/> 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> <li><input type="checkbox"/> Pregnancy</li> <li><input type="checkbox"/> 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.</li> <li><input type="checkbox"/> Persons with active cerebrospinal fluid/oropharyngeal communications/leaks.</li> <li><input type="checkbox"/> Close contacts and caregivers of severely immunosuppressed persons who require a protected environment.</li> <li><input type="checkbox"/> Persons with cochlear implants (due to the potential for CSF leak, which might exist for some period of time after implantation. 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> <li><input type="checkbox"/> Altered Immunocompetence</li> <li><input type="checkbox"/> Anatomic or functional asplenia (e.g. sickle cell disease)</li> </ul> <p><b>Precautions</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> GBS &lt;6 weeks after a previous dose of influenza vaccine</li> <li><input type="checkbox"/> Asthma in persons aged 5 years old or older</li> <li><input type="checkbox"/> Medical conditions which might predispose to higher risk of complications attributable to influenza(d)</li> <li><input type="checkbox"/> Moderate or severe acute illness with or without fever</li> </ul> |
| <input type="checkbox"/> Meningococcal conjugate vaccines (MenACWY) | <input type="checkbox"/> Temporary through: _____/_____<br>mm/ yyyy<br><input type="checkbox"/> Permanent | <p><b>Contraindications</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component, including yeast</li> </ul> <p><b>Precautions</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Moderate or severe acute illness with or without fever</li> </ul>  |

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|--|---|--|
| <input type="checkbox"/> Measles-Mumps-Rubella (MMR) | <input type="checkbox"/> Temporary through: _____/_____<br>mm/ yyyy<br><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<br><input type="checkbox"/> Pregnancy<br><input type="checkbox"/> 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)<br><input type="checkbox"/> Family history of altered immunocompetence (i) <p><b>Precautions</b></p> <input type="checkbox"/> Recent ( $\leq 11$ months) receipt of antibody-containing blood product (specific interval depends on product)<br><input type="checkbox"/> History of thrombocytopenia or thrombocytopenic purpura<br><input type="checkbox"/> Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing (k)<br><input type="checkbox"/> Moderate or severe acute illness with or without fever |
| <input type="checkbox"/> Pneumococcal (PCV13)        | <input type="checkbox"/> Temporary through: _____/_____<br>mm/ yyyy<br><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 <p><b>Precautions</b></p> <input type="checkbox"/> Moderate or acute illness with or without fever  |
| <input type="checkbox"/> Tdap                        | <input type="checkbox"/> Temporary through: _____/_____<br>mm/ yyyy<br><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<br><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 previous dose of DTP, DTaP, or Tdap <p><b>Precautions</b></p> <input type="checkbox"/> GBS $< 6$ weeks after a previous dose of tetanus-toxoid-containing vaccine<br><input type="checkbox"/> Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized<br><input type="checkbox"/> History of Arthus-type hypersensitivity reactions after a previous   |

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|---|--|---|
|   |  | <p>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</p> <p><input type="checkbox"/> Moderate or severe acute illness with or without fever</p>  |
| <input type="checkbox"/> <b>Varicella</b> | <input type="checkbox"/> <b>Temporary through:</b><br>_____/_____<br>mm/ yyyy<br><input type="checkbox"/> <b>Permanent</b> | <p><b>Contraindications</b></p> <p><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component</p> <p><input type="checkbox"/> 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)</p> <p><input type="checkbox"/> Pregnancy</p> <p><input type="checkbox"/> Family history of altered immunocompetence (j)</p> <p><b>Precautions</b></p> <p><input type="checkbox"/> Recent (&lt;11 months) receipt of antibody-containing blood product (specific interval depends on product)</p> <p><input type="checkbox"/> Moderate or acute illness with or without fever</p> |

**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
- 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:

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**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." Conn. Gen. Stat. § 19a-131b(a).