# Request for Medical Exemption From Compulsory Immunization

Name of Primary Care Provider: _____

**Please mark** the contraindications/precautions that apply to this patient.
**Write** a brief explanation of the reason the child requires exemption. [**Required** - on second page]
**Sign** and **date** the form.
**Attach** a copy of the child's most current immunization record and supporting health care information.
**Submit** to the Bureau for Public Health, Immunization Officer.

Name of Patient_____DOB_____
Name of Parent/Guardian_____
Address (patient/parent)_____
_____
School name and county _____

Medical contraindications for immunizations are based upon the most recent General Recommendations of the Advisory Committee on Immunization Practices (**ACIP)**, Public Health Services, U.S. Department of Health and Human Services, published in the Centers for Disease Control and Prevention publication, the Morbidity and Mortality Weekly Report (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6002a1.htm?s_cid=rr6002a1_e).

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 | X | |
|---|---|---|
| **DTaP** | | **Contraindications** |
| | ☐ | ♦ Severe allergic reaction after a previous dose or to a vaccine component (see "reactions" below) |
| | ☐ | ♦ Encephalopathy within seven days after receipt of previous dose of DTP or DTaP |
| | ☐ | ♦ Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy: defer DTaP until neurologic status clarified and stabilized |
| | | **Precautions** |
| | ☐ | ♦ Fever greater than 40.5°C (104.9°F) ≤48 hours after vaccination of previous dose of DTP or DTaP |
| | ☐ | ♦ Hypotonic-hyporesponsive episode ≤48 hours after vaccination of previous dose of DTP or DTaP |
| | ☐ | ♦ Seizure within 72 hours after vaccination of previous dose of DTP or DTaP |
| | ☐ | ♦ Persistent, inconsolable crying lasting three hours or more ≤48 hours after receiving a previous dose of DTP or DTaP |
| | ☐ | ♦ Moderate or acute illness with or without fever |
| **Meningococcal** | | **Contraindications** |
| | ☐ | ♦ Severe allergic reaction after a previous dose or to a vaccine component (see "reactions" below) |
| | | **Precautions** |
| | ☐ | ♦ Moderate or acute illness with or without fever |
| **IPV Polio** | | **Contraindications** |
| | ☐ | ♦ Severe allergic reaction after a previous dose or to a vaccine component (see "reactions" below) |
| | | **Precautions** |
| | ☐ | ♦ Pregnancy |
| | ☐ | ♦ Moderate or acute illness with or without fever |
| **Hib** | | **Contraindications** |
| | ☐ | ♦ Severe allergic reaction after a previous dose or to a vaccine component (see "reactions" below) |
| | ☐ | ♦ Age <6 weeks |
| | | **Precaution** |
| | ☐ | ♦ Moderate or acute illness with or without fever |

| | | |
|---|---|---|
| **MMR** | ☐<br>☐<br>☐<br><br>☐<br><br>☐<br>☐ | **Contraindications**<br>♦ Severe allergic reaction after a previous dose or to a vaccine component (see "reactions" below)<br>♦ Pregnancy<br>♦ Known severe immunodeficiency (e.g., hematologic and solid tumors or severely symptomatic human immunodeficiency virus [HIV] infection)<br>**Precautions**<br>♦ Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product)<br>♦ History of thrombocytopenia or thrombocytopenic purpura<br>♦ Moderate or acute illness with or without fever |
| **Tdap** | ☐<br>☐<br>☐<br><br>☐<br>☐<br><br>☐<br>☐ | **Contraindications**<br>♦ Severe allergic reaction after a previous dose or to a vaccine component (see "reactions" below)<br>♦ Severe allergy to latex<br>♦ Encephalopathy within seven days after receipt of a previous dose of DTP or DTaP<br>**Precautions**<br>♦ Guillian-Barré syndrome ≤6 weeks after a previous dose of tetanus toxoid-containing vaccine<br>♦ Progressive neurologic disorder, including progressive encephalopathy, or uncontrolled epilepsy, until the condition has stabilized<br>♦ Arthus reaction following a previous dose of any vaccine containing tetanus toxoid or diphtheria<br>♦ Moderate or acute illness with or without fever |
| **Varicella** | ☐<br>☐<br>☐<br><br>☐<br><br>☐ | **Contraindications**<br>♦ Severe allergic reaction after a previous dose or to a vaccine component (see "reactions" below)<br>♦ Substantial suppression of cellular immunity<br>♦ Pregnancy<br>**Precautions**<br>♦ Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product)<br>♦ Moderate or acute illness with or without fever |
| **Other Allergic Reactions/Other Type of Medical Contraindication** | ☐ | **Other Contraindications, Precautions or Considerations**<br>♦ Vaccinations(s) and dose number(s) for which other serious VAE have occurred<br>_____<br>♦ Description of adverse event:<br>_____ |

**EXPLANATION of Exemption:** _____

_____

_____

_____

**Attach most current immunization record**

**Permanent or Temporary?** _____

**If temporary, date of re-evaluation** _____

**Physician's Name** _____

**Address** _____

**Phone** _____ **Fax** _____

**Physician's Signature/Date** _____

If the provider is unable to submit this form electronically through WVSIIS, this form may be mailed to:

Immunization Officer
WV Bureau for Public Health
350 Capitol Street, Room 125
Charleston, WV 25301

**Health care providers may contact the Division of Immunization Services at 1-800-642-3634 for consultation regarding contraindications, precautions and vaccine adverse effects.**

West Virginia Department of Health and Human Resources
Bureau for Public Health ● Division of Immunization Services

**Immunization Officer Use Only:** _____**Approve** _____**Deny**

**Immunization Officer Signature:** _____ **Date:**_____