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

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:**_____