Request for Certified 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)____
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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	
Diphtheria, tetanus, pertussis (DTaP) **Tetanus, diphtheria, pertussis (Tdap)** **Tetanus, diphtheria (DT, Td)**		**Contraindications**
	☐	♦ Severe allergic reaction after a previous dose or to a vaccine component (see "reactions" below)
	☐	♦ Encephalopathy, not attributable to another identifiable cause, within seven days after receipt of previous dose of DTP or DTaP
		Precautions
	☐	♦ For DTaP and Tdap only: Progressive neurologic disorder, (including infantile spasms for DTaP), uncontrolled seizures, progressive encephalopathy: defer until a treatment regimen has been established and the condition has stabilized.
	☐	♦ Guillain-Barre syndrome within 6 weeks after a previous dose of tetanus toxoid containing vaccine.
	☐	♦ Moderate or severe acute illness with or without fever
	☐	♦ History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria or tetanus-toxoid containing vaccine.
Meningococcal		**Contraindications**
	☐	♦ Severe allergic reaction after a previous dose or to a vaccine component (see "reactions" below)
		Precautions
	☐	♦ Moderate or severe 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 severe acute illness with or without fever
Hep B		**Contraindications**
	☐	♦ Severe allergic reaction after a previous dose or to a vaccine component (see "reactions" below)
	☐	♦ Hypersensitivity to yeast
		Precaution
	☐	♦ Moderate or severe 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, chemotherapy, congenital immunodeficiency or long term immunosuppressive therapy) or severely symptomatic human immunodeficiency virus [HIV] infection) ♦ Family history of congenital or hereditary immunodeficiency in first-degree relatives (e.g., parents and siblings), unless the immune competence of the potential vaccine recipient has been substantiated clinically or verified by a lab test. **Precautions** ♦ Recent ($\leq$11 months) receipt of antibody-containing blood product (specific interval depends on product) ♦ History of thrombocytopenia or thrombocytopenic purpura ♦ Moderate or severe acute illness with or without fever
Varicella	☐ ☐ ☐ ☐ ☐ ☐	**Contraindications** ♦ Severe allergic reaction after a previous dose or to a vaccine component (see "reactions" below) ♦ Substantial suppression of cellular immunity ♦ Pregnancy ♦ Family history of congenital or hereditary immunodeficiency in first-degree relatives **Precautions** ♦ Recent ($\leq$11 months) receipt of antibody-containing blood product (specific interval depends on product) ♦ Moderate or severe 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: ____

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Attach most current immunization record

Permanent or Temporary? ______________________

If temporary, date of re-evaluation ________________

Physician's Name ______________________________

Address ______________________________________

Phone _________________ **Fax** _________________.

Date: **Sign Below this line**

I ____ certify that the physical condition of the above-named patient is such that the specified immunization(s) is contraindicated or there exists a specified precaution to a specified vaccine as indicated above.

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:**____________