Yale Campus Health

Yale University Employee / Staff / Faculty

Medical Exemption Certificate for Required Immunizations

THIS FORM IS REQUIRED TO BE UPLOADED TO THE HEALTH ON TRACK SYSTEM FOR REVIEW.

Directions for Employee/Faculty/Staff Member:

Complete the demographic information below and then have your medical provider complete the other applicable sections.

Last Name	**First Name**	**Date of Birth:** ___ /___ /_____ Month Day Year	**NET ID**
E-mail		**Phone**	
Department			

Directions for Medical Provider:

Part 1. Please mark the vaccine(s), exemption duration, and all contraindications/precautions that apply to this Employee / Staff member 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
❒ **Varicella**	❒ **Temporary through:** _____ /_____ **Month Year** ❒ **Permanent**	**Contraindications** ❒ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ❒ 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) ❒ Pregnancy ❒ Family history of altered immunocompetence (j) **Precautions** ❒ Recent (<11 months) receipt of antibody-containing blood product (specific interval depends on product) ❒ Moderate or acute illness with or without fever

CDC Recognized Contraindications and Precautions

Vaccine	Exemption Duration	ACIP Contraindications and Precautions
❒ **Measles-Mumps-Rubella (MMR)**	❒ **Temporary through:** _____ /_____ **Month Year** ❒ **Permanent**	**Contraindications** ❒ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ❒ Pregnancy ❒ 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) ❒ Family history of altered immunocompetence (i) **Precautions** ❒ Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) ❒ History of thrombocytopenia or thrombocytopenic purpura ❒ Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing (k) ❒ Moderate or severe acute illness with or without fever
❒ **Tetanus (Td or Tdap)**	❒ **Temporary through:** _____ /_____ **Month Year** ❒ **Permanent**	**Contraindications** ❒ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ❒ 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 **Precautions** ❒ GBS <6 weeks after a previous dose of tetanus-toxoid–containing vaccine ❒ Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized. ❒ 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. ❒ Moderate or acute illness with or without fever
❒ **COVID-19**	❒ **Temporary through:** _____ /_____ **Month Year** ❒ **Permanent**	**Contraindications** ❒ History of a **severe** allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine **Precautions** ❒ History of a diagnosed **non-severe** allergy to a component of the COVID-19 vaccine ❒ History of a n**on-severe,** immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of one COVID-19 vaccine type. ❒ History of MIS-C or MIS-A ❒ History of myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine ❒ Moderate or acute illness with or without fever

Part 2. 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 1.

Vaccine(s), list all that apply: _____

_____
For each vaccine listed in Part 2 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 previously documented reaction that is correlated to a vaccination.

❒ Other condition/reaction not listed above (must specify):_____

(Continued on next page)

Please provide an explanation of the reaction/condition listed above:

_____

Part 3. Statement of Clinical Opinion

In accord with the legal requirements of the Americans with Disabilities Act, the vaccine(s) indicated above is/are in my clinical opinion medically contraindicated for this Employee / Faculty / Staff member due to the physical condition as explained above.

Name of Medical Provider granting exemption: _____

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

❒ Physician (MD or DO) ❒ Physician Assistant ❒ APRN

NPI:_____

Phone number: _____ Email: _____

Clinician's Signature: _____

Date: _____