Office of Health Services

Request for Medical Exemption from Mandatory Immunization

Student Information

Name of Student (first/middle/last)**:**		
Date of Birth:	**Spirit ID #:**	
Primary Phone:	**SPU Email Address:**	
Address:		
City:	**State:**	**Zip Code:**
Signature:		**Date:**

Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP), available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html or https://redbook.solutions.aap.org/redbook.aspx

Please check the website to ensure that you are reviewing the most recent ACIP information. Please note that the presence of a moderate to severe acute illness with or without fever is a precaution to administration of all vaccines However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication.

ACIP Contraindications and Precautions to Vaccination for Mandatory Vaccines		
Vaccine	**Exemption Length**	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
❑ **Hepatitis B (HepB)**	❑ Temporary through: _____ ❑ Permanent	**Contraindications** ❑ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to vaccine component
❑ **Meningococcal (MenACWY)**	❑ Temporary through: _____ ❑ Permanent	**Contraindications** ❑ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to vaccine component

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
❑ **MMR**	❑ Temporary through: _____ ❑ Permanent	**Contraindications** ❑ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to vaccine component ❑ Pregnancy ❑ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with human immunodeficiency virus [HIV] infection who are severely immunocompromised) ❑ 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 laboratory test **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
❑ **COVID-19** *two mRNA vaccines (Pfizer-BioNTech, Moderna) and one viral vector vaccine (Janssen [Johnson & Johnson])*	❑ Temporary through: _____ ❑ Permanent	**Contraindications** ❑ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to vaccine component ❑ Pregnancy ❑ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with human immunodeficiency virus [HIV] infection who are severely immunocompromised) ❑ 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 laboratory test **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

Attestation

I am a physician (M.D. or D.O) or physician assistant (PA) licensed to practice medicine in a jurisdiction of the United States or an advanced practice nurse licensed in a jurisdiction of the United States.

By signing below, I affirm that I have reviewed the current ACIP Contraindications and Precautions and affirm that the stated contraindication(s)/precaution(s) is enumerated by the ACIP and consistent with established national standards for vaccination practices. I understand that I might be required to submit supporting medical documentation. I also understand that any misrepresentation might result in referral to the New Jersey State Board of Medical Examiners and/or appropriate licensing/regulatory agency.

Healthcare Provider Name (please print):		
Specialty:		
NPI #:	**License #:**	**State of Licensure:**
Phone:		**Fax:**
Email Address:		
Address:		
City:	**State:**	**Zip Code:**
Signature:		**Date:**

Instructions for Submission

Please note, submitting this request does not guarantee approval. Please allow 7-10 business days for your request to be processed. Upon review, you will be notified in writing if the exemption has been granted. At any time the University reserves the right to request additional supporting documentation.

Once the form has been completed by the student and the healthcare provider, the student should then email the completed document to Health Services (healthservices@saintpeters.edu).