

North Carolina Department of Health and Human Services
Women's and Children's Health Section • Immunization Branch

MEDICAL EXEMPTION STATEMENT

Purpose: To provide physicians, licensed to practice medicine in North Carolina, a mechanism to document a true medical contraindication/precaution to an immunization(s). This form does not need approval from the State Health Director. This form can be accepted by agencies that require proof of immunizations. For medical exemptions NOT listed in the table below, submit the Physician's Request for Medical Exemption form (Form: DHHS 3995) to the State Health Director for approval, available at <http://www.immunize.nc.gov/schools/ncexemptions.htm>

Name of Patient _____ DOB _____

Name of Parent/Guardian _____ Primary Phone () _____

Home Address (Patient/Parent) _____ County _____

Name of Child Care/School/College/University _____

Medical contraindications and precautions for immunizations are described in the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP), available at <http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm>

A **contraindication** is a condition in a recipient that increases the risk for a serious adverse reaction. A vaccine will not be administered when a contraindication is present. A **precaution** is a condition in a recipient that might increase the risk for a serious adverse reaction or that might compromise the ability of the vaccine to produce immunity. Under normal conditions, vaccinations should be deferred when a precaution is present.

Vaccine	Check all true contraindications and precautions that apply to this patient below:
<input type="checkbox"/> Diphtheria, tetanus, pertussis (DTaP) <input type="checkbox"/> Tetanus, diphtheria, pertussis (Tdap) <input type="checkbox"/> Tetanus, diphtheria (DT, Td)	<p>Contraindications</p> <ul style="list-style-type: none"> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. <input type="checkbox"/> For pertussis-containing vaccines: encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizure) not attributable to another identifiable cause within 7 days of administration of DTaP or DTP (for DTaP); or of previous dose of DTaP, DTP, or Tdap (for Tdap). <p>Precautions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Moderate or severe acute illness with or without fever. <input type="checkbox"/> Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus toxoid-containing vaccine. <input type="checkbox"/> History of arthus-type hypersensitivity reaction after a previous dose of a tetanus or diphtheria toxoid-containing vaccine; defer until at least 10 years have elapsed since the last tetanus-toxoid containing vaccine. <input type="checkbox"/> For pertussis-containing vaccines: progressive or unstable neurologic disorder (including infantile spasms for DTaP), uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized. <p>Additional Precautions that only apply to DTaP</p> <ul style="list-style-type: none"> <input type="checkbox"/> Temperature of 105° F or higher (40.5° C or higher) within 48 hours after vaccination with a previous dose of DTP/DTaP. <input type="checkbox"/> Collapse or shock-like state (i.e., hypotonic hyporesponsive episode) within 48 hours after receiving a previous dose of DTP/DTaP. <input type="checkbox"/> Seizure within 3 days after receiving a previous dose of DTP/DTaP. <input type="checkbox"/> Persistent, inconsolable crying lasting 3 or more hours within 48 hours after receiving a previous dose of DTP/DTaP.
<input type="checkbox"/> Measles, mumps, rubella (MMR)	<p>Contraindications</p> <ul style="list-style-type: none"> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. <input type="checkbox"/> Known severe immunodeficiency (e.g., congenital immunodeficiency, malignancy, chemotherapy, long-term immunosuppressive therapy, or human immunodeficiency virus [HIV] infection with CD4+ T-lymphocyte count \leq 15%). <input type="checkbox"/> Pregnancy. <p>Precautions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Moderate or severe acute illness with or without fever. <input type="checkbox"/> Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product). <input type="checkbox"/> History of thrombocytopenia or thrombocytopenic purpura. <input type="checkbox"/> Need for tuberculin skin testing (Measles vaccine might suppress tuberculin reactivity temporarily)

<input type="checkbox"/> Varicella (Var)	<p>Contraindications</p> <ul style="list-style-type: none"> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. <input type="checkbox"/> Known severe immunodeficiency (e.g., congenital immunodeficiency, malignancy, chemotherapy, long-term immunosuppressive therapy, or human immunodeficiency virus (HIV) infection with CD4+ T-lymphocyte count \leq 15%. <input type="checkbox"/> Pregnancy. <p>Precautions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Moderate or severe acute illness with or without fever <input type="checkbox"/> Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product) <input type="checkbox"/> Receipt of specific antivirals (e.g., acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination; Avoid use of these antivirals for 14 days after vaccination.
<input type="checkbox"/> Inactivated Polio Virus (IPV)	<p>Contraindications</p> <ul style="list-style-type: none"> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. <p>Precautions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Moderate or severe acute illness with or without fever. <input type="checkbox"/> Pregnancy.
<input type="checkbox"/> Hepatitis B (Hep B)	<p>Contraindications</p> <ul style="list-style-type: none"> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. <p>Precautions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Moderate or severe acute illness with or without fever. <input type="checkbox"/> Infant weighing less than 2000 grams (4 lbs, 6.4 oz) if mother is documented hepatitis B surface antigen (HbsAg) negative at the time of the infant's birth.
<input type="checkbox"/> Haemophilus Influenza type B (HIB)	<p>Contraindications</p> <ul style="list-style-type: none"> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. <input type="checkbox"/> Age younger than 6 weeks. <p>Precautions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Moderate or severe acute illness with or without fever.
<input type="checkbox"/> Pneumococcal (PCV13)	<p>Contraindications</p> <ul style="list-style-type: none"> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component, including any diphtheria toxoid-containing vaccine. <p>Precautions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Moderate or severe acute illness with or without fever.
<input type="checkbox"/> Meningococcal (MCV4)	<p>Contraindications</p> <ul style="list-style-type: none"> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <p>Precautions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Moderate or severe acute illness with or without fever

A physician (M.D. or D.O) licensed to practice medicine in North Carolina must complete and sign this form.

Date exemption ends: _____

N.C. Physician's Name (please print) _____ Phone: _____

Address _____

N.C. Physician's Signature _____ Date _____

Instructions:

1. Complete and sign the form.
2. Attach a copy of the most current Immunization record.
3. Retain a copy for the patient's medical record.
4. Return the original to the person requesting this form.

For questions call (919) 707-5550

Additional copies of this form can be accessed at: <http://www.immunize.nc.gov/schools/ncexemptions.htm>