Request for Medical Exemption from Influenza Vaccination

Student Name:_____ School: _____Student Phone #:_____
Physician Name:_____ Physician phone #: _____
Address:_____ State License Number: _____

Dear Physician:

As a patient safety initiative, Healthcare Facilities affiliated with FVHCA are requiring influenza vaccinations for all students participating in clinical experiences or internships at their sites, similar to other required vaccinations such as MMR. For decades, influenza vaccination has been recommended for health care workers and has been shown in study settings to be effective in protecting patients. Your patient (student) is requesting to be exempt from this vaccination. **Medical exemption from influenza vaccination is allowed ONLY for recognized contraindications** (CDC, Prevention and control of seasonal influenza with vaccines: Recommendations of the advisory committee on immunization practices (ACIP), MMWR August 18, 2011/60 (Early Release); 1-6). Please complete the information below regarding your patient's request for a medical exemption.
Thank you.

My patient should not be vaccinated against influenza for the following reason (please check reason):

- ☐ Recognized contraindication to influenza for the following reason:
  - ☐ **Severe allergic reaction to eggs. Date of reaction:** _____
    - Defined as developing hives, swelling of the lips of tongue, difficulty breathing.
    - Does not generally result in only gastro-intestinal symptoms.
    - The amount of egg protein in influenza vaccines is extremely small. People who can tolerate eating lightly cooked egg, such as a scrambled egg can generally tolerate the influenza vaccine.
  - ☐ **History of previous severe allergic reaction to the influenza vaccine or component of the vaccine. Date of reaction:** _____
    - Defined as developing hives, swelling of the lips or tongue, difficulty breathing.
    - Does not include sore arm, local reaction or subsequent upper respiratory tract infection.
  - ☐ **History of Guillain-Barre syndrome within six (6) weeks of receiving a previous vaccine. Date of reaction:** _____
    - People with this history can choose to receive the vaccine.
  - ☐ **Bone marrow transplant within the previous six (6) months. Date of transplant:**_____
- ☐ Other. Please describe in space below. (These requests will be reviewed on a case-by-case basis by the individual Healthcare Facility. _____

I certify that my patient has the above contraindication and request medical exemption from the influenza vaccination.

Physician Signature:_____ **Date:** _____
(Signature stamps will not be accepted)

I (**student**) understand that not being vaccinated as a result of an exemption may require me to wear respiratory protection at all times during the flu season. (Follow Healthcare Facility policies)

I authorize my school to release this information to the Healthcare Facility where my clinical experience/internship has been requested. I authorize the Healthcare Facility to contact my physician for clarification of any exemption request.

I understand that I may revoke this authorization by notifying my school coordinator and submitting proof of influenza vaccination.

Student Signature: _____ **Date:** _____

NOTE: Return completed FVHCA Medical Exemption form to School Coordinator prior to experience/internship.

Updated July 27, 2015