Vaccination – Medical Exemption Request

The Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) recommends that healthcare workers are immune to specific vaccine preventable diseases. While CSI does not require COVID-19 vaccinations at this time, in order to promote health and safety, some of our clinical affiliates follow ACIP recommendations and therefore require CSI students and faculty to be vaccinated before entering their facilities.

Section I: To be completed by student

Applicant Information: (Applicant please complete)

Name:	**CSI ID number:**	**Date:**
Program/Semester:	**Phone Number:**	☐ **Clinicals** ☐ **Volunteer** ☐ **Other**

I have made myself familiar with information regarding these vaccinations, and specifically on the COVID-19 vaccination. I am requesting an exemption from the vaccinations marked below due to a medical reason. **I am aware that I am required to provide documentation in support of this exemption request. I understand that my application will bereviewed and must be approved.** I further understand that if my request is approved, I will be required to wear personal protective equipment (i.e., a procedure mask) and/or I may be reassigned to an alternate location.

I understand that if my exemption request is not approved, I will be unable to attend clinical experiences in facilities with immunization requirements. Failure to complete clinical experiences may lead to failing grades and my inability to successfully graduate. Alternative clinical educational experiences may be available for those lacking vaccinations or exemptions. However,these alternative clinical experiences are not guaranteed and vary based on a program-to-program basis.

I am requesting exemption from one or more of these vaccines:

☐ Td or Tdap	☐ Hepatitis B	☐ Meningococcal
☐ Measles, mumps, rubella (MMR)	☐ Varicella	☐ Influenza
☐ Moderna Covid – 19	☐ Pfizer Covid – 19	☐ J & J Covid-19

Signature of Student:____DOB:____________________

Section II: To be completed by applicant's Physician or Primary Care Provider ONLY

Physician/Provider: Please check the box for true contraindications/precautions that apply to this patient for the vaccine the patient is requesting exemption from, then sign and date the bottom of the form. **(Note: Providers maynot sign their own exemption.)**

Medical contraindications for immunizations are determined by the manufacturer, the most recent Adult Immunization Recommendations of the ACIP, Public Health Services, and the U.S. Department of Health and Human Services. A **contraindication** is a condition in a recipient that increases the risk for a serious adverse reaction. A vaccine will notbe administered when a contraindication is present. A **precaution** is a condition in a recipient that might increase therisk for a serious adverse reaction or that might compromise the ability of the vaccine to produce immunity. If you check any of the **precaution** boxes you may be contacted by Employee Health for clarification.

Student Name:____**DOB** ____________________

Vaccine	Contraindications	Precautions
Influenza, inactivated	☐ Severe allergic reaction (e.g. anaphylaxis) after previous dose of any influenza vaccine or to a vaccine component, including egg protein. ☐	☐ Moderate or severe acute illness with our without fever ☐ History of Guillain-Barré Syndrome within 6 weeks of previous influenza vaccination ☐ Hives – adults who experience only hives with exposure to eggs may receive recombinant ☐ influenza vaccine (RIV)
Influenza, recombinant (RIV)	Severe allergic reaction (e.g. anaphylaxis) after previous does of RIV or to a vaccine component. RIV does not contain any egg protein. ☐	Moderate or severe acute illness with or ☐ without fever History of Guillain-Barré Syndrome within 6 ☐ weeks of previous influenza vaccination
Influenza, live attenuated (LAIV)	Severe allergic reaction (e.g. anaphylaxis) to any component of the vaccine or to a previous ☐ dose of any influenza vaccine ACIP recommends that LAIV not be used in the following populations: (please circle one) pregnant women, immunosuppressed adults, adults with egg allergy of any severity, adults who have taken influenza antiviral medications (amantadine, rimantadine, zanamivir, or oseltamivir) within the previous 48 hours ☐	Moderate or severe acute illness with our ☐ without fever History of Guillain-Barre' Syndrome within 6 ☐ weeks of previous influenza vaccination ☐ Asthma in persons aged 5 years and older Other chronic medical conditions, e.g. other chronic lung diseases, chronic cardiovascular disease (excluding isolated hypertension), diabetes, chronic renal or hepatic disease, hematologic disease, neurologic disease, and ☐ metabolic disorders
Tetanus, diphtheria, pertussis (Tdap); tetanus diphtheria (Td)	Severe allergic reaction (e.g. anaphylaxis) after ☐ a previous dose or to a vaccine component For pertussis-containing vaccines: encephalopathy (e.g. coma, decreased level of consciousness, or prolonged seizures) not attributable to another identifiable cause within 7 days of administration of a previous dose of Tdap, diphtheria and tetanus toxoids and pertussis (DTP), or diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine ☐	Moderate or severe acute illness with our ☐ without fever Guillain-Barre' Syndrome within 6 weeks after a previous dose of tetanus toxoid-containing ☐ vaccine For pertussis containing vaccines: Progressive or unstable neurologic disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has ☐ stabilized
Varicella	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, or patients with human immunodeficiency virus ☐ (HIV) infection Pregnancy	Recent (within 11 months) receipt of antibody-containing blood product (specific ☐ interval depends on product) Moderate or severe acute illness with our ☐ without fever Receipt of specific antivirals (i.e. acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination; avoid use of these antiviral drugs for 14 days after vaccination

Measles, mumps, rubella (MMR)	☐ 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, or long-term immunosuppressive therapy, or patients with HIV infection who are severely immunocompromised. ☐ Pregnancy	☐ Moderate or severe acute illness with our without fever ☐ Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product) ☐ History of thrombocytopenia or thrombocytopenic purpura ☐ Need for tuberculin skin testing
Meningococcal	☐ Severe allergic reaction (e.g. anaphylaxis) after a previous dose or to a vaccine component	☐ Moderate or severe acute illness with our without fever
Hepatitis B	☐ Severe allergic reaction (e.g. anaphylaxis) after a previous dose or to a vaccine component	☐ Moderate or severe acute illness with our without fever
Moderna Covid – 19 Pfizer Covid - 19	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of an mRNA COVID-19 vaccine (Moderna or Pfizer-BioNTech) ☐ Immediate allergic reaction* of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine	☐ History of an immediate allergic reaction to any other vaccine or injectable therapy (i.e., intramuscular, intravenous, or subcutaneous vaccines or therapies) • This includes people with a reaction to a vaccine or injectable therapy that contains multiple components, one of which is a vaccine component, but for whom it is unknown which component elicited the immediate allergic reaction. ☐ People with a contraindication to Janssen COVID-19 vaccine have a precaution to both mRNA vaccines ☐ Moderate to severe acute illness
Johnson and Johnson Covid-19	☐ Severe allergic reaction (e.g., anaphylaxis) to a previous dose or component of Janssen COVID-19 Vaccine. ☐ Immediate allergic reaction* of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine.	☐ History of an immediate allergic reaction* to any other vaccine or injectable therapy (i.e., intramuscular, intravenous, or subcutaneous vaccines or therapies.) • This includes people with a reaction to a vaccine or injectable therapy that contains multiple components, one of which is a vaccine component, but in whom it is unknown which component elicited the immediate allergic reaction. ☐ People with a contraindication to Janssen COVID-19 vaccine have a precaution to both mRNA vaccines ☐ Moderate or severe acute illness

*An immediate allergic reaction is defined as any hypersensitivity-related signs or symptoms, such as urticaria, angioedema, respiratory distress (e.g., wheezing, stridor), or anaphylaxis that occur within 4 hours following exposure to a vaccine or medication.

Source: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html

https://www.cdc.gov/vaccines/covid-19/info-by-product/moderna/index.html#:~:text=Contraindications%3A%20%E2%97%8B%20Severe%20allergic,component%20of%20the%20vaccine.

https://www.cdc.gov/vaccines/covid-19/info-by-product/janssen/index.html

Section III: To be completed by applicant's Physician or Primary Care Provider ONLY

☐ Temporary Exemption Effective Date:________________________________End Date:___________________________

☐ Permanent Exemption Effective Date: _________________________________

For any boxes checked above, please describe symptoms or reaction:

____

____

____

Physician/Provider Name: (PLEASE PRINT)__________________________________Phone:________________

Address:____

Physician/Provider Signature:____Date:_______________

Upload Form to your Complio account or send to
glaird@csi.edu for processing

For Health Sciences and Human Services use only:

Request: ☐ Approved Date_________________

☐ Denied Date___________________

Reason:____