Zip Code:

Signature: **Date:**

Medical contraindications and precautions for immunizationhttps://www.cdc.gov/vaccines/hcp/acip-recs/ are based on the most recent General Recommendations l

general-recs/contraindications.html or https://redbook.solutions.aap.org/redbook.aspx

Please check the website to ensureccines However, as acute illnesses are

short-lived, medical exemptions should not be submitted for this indication.

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
❑ **Hepatitis B (HepB)**	❑ Temporary through: ____________ ❑ Permanent	**Contrƒaaa** **Contraindications** ❑ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to v]]v

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 thronjy

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).