LOYOLA UNIVERSITY CHICAGO
1870 AD MAJOREM DEI GLORIAM

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Vaccine Medical Exemption Request Form

A student may be exempted from one or more of the specific immunization requirements by written statement by a provider indicating the nature and probable duration of the medical condition or circumstances that contraindicates those immunizations, identifying the specific vaccines that could be detrimental to the student's health. Illinois College Immunization Code: Section 694.200 Medical Exemption
Students understand that in the event of an outbreak/exposure, you may be asked to isolate and/or quarantine in coordinance to the department of public health recommendations. https://ilga.gov/commission/jcar/admincode/077/077006940C02000R.html

Section I: Should be completed by student or guardian (if student is under 18 years old)

Name of Student: _____ Student ID #:_____ Date of Birth: _____
First/Middle/Last
Name of Parent/Guardian (if under 18): _____

Primary Home Address: _____

Student Email Address: _____ Primary Phone: _____

Signature: _____ Date: _____
Student or guardian if under 18

Section II: Should be completed by medical provider
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. Please check the website to ensure that you are reviewing the most recent ACIP information. Please note that the presence of a sore arm, local reaction, and moderate to severe acute illness with or without fever are possible after administration of all vaccines. However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication. Please review the ACIP Guide to confirm that any noted condition is not commonly misperceived as a contraindication or precaution in the above ACIP link.

Table 1. ACIP Contraindications and Precautions to Vaccination

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
□ DTaP, Tdap □ DT, Td	□ Temporary through: _____ □ Permanent	**Contraindications** □ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component □ Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of a previous dose or DTP, DTaP, or Tdap □ Other: Explain fully below **Precautions** □ Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP or Tdap until neurologic status clarified and stabilized □ Guillan-Barre (GBS) within 6 weeks after previous dose of tetanus-toxoid containing vaccine □ History of Arthus-type hypersensitivity reaction following a previous dose of tetanus and/or diphtheria toxoid-containing vaccine: defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid containing vaccine □ Moderate or severe acute illness with or without fever
□ Hepatitis B	□ Temporary through: _____ □ Permanent	**Contraindications** □ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component □ Hypersensitivity to yeast □ Other: Explain fully below **Precautions** □ Moderate or severe acute illness with or without fever
□ Influenza, Inactivated injectable (IIV)	□ Temporary through: _____ □ Permanent	**Contraindications** □ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component □ Other: Explain fully below **Precautions** □ Guillan-Barre (GBS) within 6 weeks after previous dose of influenza vaccine □ Moderate or severe acute illness with or without fever □ Egg allergy other than hives, e.g., angioedema, respiratory distress, lightheadedness, recurrent emesis; or required epinephrine or another emergency medical intervention *IIV may be administered in an inpatient or outpatient medical setting and under the supervision of a health care provider who is able to recognize and manage severe allergic conditions*

□ MMR (Measles, Mumps, Rubella	□ Temporary through: _____ □ Permanent	**Contraindications** □ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component □ Pregnancy Estimated Date of Confinement (EDC) _____ (month, day, year) □ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) □ Family history of altered immunocompetence □ Other: Explain fully below **Precautions** □ Recent (< 11 months) receipt of antibody-containing blood products (specific interval depends on product) □ History of thrombocytopenia or thrombocytopenic purpura □ Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing □ Moderate or severe acute illness with or without fever
□ Meningococcal (MenACWY	□ Temporary through: _____ □ Permanent	**Contraindications** □ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component including yeast □ Other: Explain fully below **Precautions** □ Moderate or severe acute illness with or without fever □ Preterm birth (MenACWY-CRM)
□ Varicella	□ Temporary through: _____ □ Permanent	**Contraindications** □ 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, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) □ Pregnancy Estimated Date of Confinement (EDC) _____ (month, day, year) □ Family history of altered immunocompetence □ Other: Explain fully below **Precautions** □ Recent (< 11 months) receipt of antibody-containing blood products (specific interval depends on product) □ Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (void use of these antiviral drugs for 14 days after vaccination □ Use of aspirin or aspirin-containing products □ Moderate or severe acute illness with or without fever
□ COVID-19 □ COVID-19 BOOSTER(S)	□ Temporary through: _____ □ Permanent	**Contraindications** □ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component of the COVID-19 vaccine **Explain in full below** □ Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine **Explain in full below** □ Other: **Explain in full below**

Other: Please explain fully the nature and probable duration of the medical condition or circumstances that contraindicate those immunizations, identifying the specific vaccines that could be detrimental to the student's health. Attach additional sheets as necessary.

_____
_____
_____
_____
_____
_____
_____

Attestation

I am a physician (M.D. or D.O.) licensed to practice medicine in a jurisdiction of the United States or an advanced practice provider (nurse practitioner or physician's assistant) 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) pose a concern or could be detrimental to the student's health.

Healthcare Provider Name (please print): _____

Signature: _____ Date: _____

State of Licensure: _____ NPI Number: _____