



# Medical Immunization Exemption Certificate For Use in Healthcare Facilities

## Section 1: Healthcare Facility and Worker Information

Name of Healthcare Facility	Street Address	City	ZIP Code	Phone
Healthcare Worker Name		Date of Birth		
Street Address	City	ZIP Code	Phone	

## Section 2: For Healthcare Provider Use Only - Provide name, address, vaccine contraindication(s), signature, and date.

Name of Healthcare Provider	Street Address	City	ZIP Code	Phone
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1. I certify that due to the contraindication(s) checked below the above named individual is exempt from receiving the required vaccine(s).
2. The contraindication(s) marked below is in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines, American Academy of Pediatrics (AAP) guidelines, or vaccine package insert instructions: (Check where applicable)

Influenza     
  MMR     
  Varicella     
  Tdap     
  Hepatitis B     
  COVID-19

Contraindications	*Precautions
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- Serious allergic reaction (e.g., anaphylaxis) after a previous vaccine dose (General for all vaccines)
- Serious allergic reaction (e.g., anaphylaxis) to a vaccine component (General for all vaccines)
- Influenza (**LAIV**) – Pregnancy, immunosuppression, certain chronic medical conditions (e.g., cochlear implant), receipt of specific antivirals 48 hours before vaccination (i.e., amantadine, rimantadine, zanamivir, or oseltamivir. Avoid use of these antivirals until 14 days after vaccination.)
- MMR – Severe immunodeficiency, due to any cause, including HIV; pregnancy
- Varicella – Substantial suppression of cellular immunity, including severely immunocompromised with HIV; pregnancy
- Tdap – Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within seven days of administration of previous dose of DTP, DTaP, or Tdap
- COVID-19 (Novavax, Janssen) – Known allergy to polysorbate

- Current moderate or severe acute illness, with or without fever (General for all vaccines)
- MMR – Recent administration of an antibody-containing blood product, history of thrombocytopenia or thrombocytopenic purpura, need for tuberculin skin testing or interferon gamma release assay testing, personal or family history of seizures
- Varicella – Recent administration of an antibody-containing blood product
- Tetanus toxoid-containing vaccine, Influenza – Guillain-Barre syndrome history within six weeks after a previous dose
- Influenza – Severe allergic reaction to egg protein
- COVID-19 – History of multi-inflammatory syndrome
- COVID-19 – History of myocarditis or pericarditis following an mRNA or Novavax COVID-19 vaccine
- COVID-19 – History of anaphylaxis after any vaccine other than COVID-19 vaccine or after any injectable therapy (i.e., intramuscular, intravenous, or subcutaneous vaccines or therapies [excluding subcutaneous immunotherapy for allergies, i.e., “allergy shots”]); People with a history of a non-severe, immediate (onset less than four hours) allergic reaction after a dose of [one type of COVID-19 vaccine](#) have a precaution to the **same type of COVID-19 vaccine**; People with an allergy-related contraindication to one type of COVID-19 vaccine have a precaution to the **other types of COVID-19 vaccines**
- Tdap – History of arthus-type hypersensitivity reactions after a previous dose of tetanus toxoid-containing vaccine; Defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid containing vaccine.
- Tdap – Progressive or unstable neurologic disorders; Defer Tdap vaccination until a treatment regimen has been established and the condition has stabilized.

Vaccine package inserts and CDC recommendations for these vaccines should be consulted for additional information on vaccine-related contraindications and precautions and for more information on vaccine excipients ([www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm](http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm)).

\*Conditions listed as precautions should be reviewed as well as recommended actions per CDC. Benefits of, and risks for, administering a specific vaccine to a person under these circumstances should be considered. If the risk from the vaccine is believed to outweigh the benefit, the vaccine should not be administered.

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**Healthcare Provider Signature**

\_\_\_\_\_  
**Date**

The identifiable information provided by the healthcare worker to the facility shall not be disclosed to any third party without the written authorization of the healthcare worker, pursuant to the Rhode Island Confidentiality Healthcare Information Act, RI General Laws chapter 5-37.1. Do not send a copy of this form to the Rhode Island Department of Health. Only non-identifying information aggregated by the facility shall be reported to the Rhode Island Department of health for statistical purposes.