



# Medical Immunization Exemption Certificate

## For Use in Public and Private Daycare, Preschool, School & College

### Instructions for completing a Medical Immunization Exemption Certificate

**Section 1:** Enter school and student information.

**Section 2:** For health care provider use only. Please provide name, address, vaccine contraindication(s), signature and date.

**Section 3:** For school use only: Obtain school signatures and dates and distribute copies as outlined below.

#### Section 1: School and Student Information

Name of Daycare, School, or Institution	Street Address	City	Zip Code	Phone
Student Name		Date of Birth	Grade/Level	
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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- I certify that due to a contraindication(s) the above named student is exempt from receiving the required vaccine(s):
- 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)

- |                               |                                      |                                      |                                    |                              |                                    |                              |                              |                              |
|-------------------------------|--------------------------------------|--------------------------------------|------------------------------------|------------------------------|------------------------------------|------------------------------|------------------------------|------------------------------|
| <input type="checkbox"/> DTaP | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> HIB       | <input type="checkbox"/> HPV | <input type="checkbox"/> Influenza | <input type="checkbox"/> IPV | <input type="checkbox"/> MCV | <input type="checkbox"/> MMR |
| <input type="checkbox"/> PCV  | <input type="checkbox"/> Td/Tdap     | <input type="checkbox"/> Rotavirus   | <input type="checkbox"/> Varicella |                              |                                    |                              |                              |                              |

Contraindications	Precautions or Temporary Contraindications
<input type="checkbox"/> Serious allergic reaction (e.g., anaphylaxis) after a previous vaccine dose. (General for all vaccines) <input type="checkbox"/> Serious allergic reaction (e.g., anaphylaxis) to a vaccine component. (General for all vaccines) <input type="checkbox"/> Previous encephalopathy not attributable to another identifiable cause within 7 days of administration of previous dose of DTaP/DTP. <input type="checkbox"/> Progressive neurological problem after DTaP/DTP <input type="checkbox"/> MMR contraindicated with immunodeficiency, due to any cause, including HIV <input type="checkbox"/> Varicella contraindicated with substantial suppression of cellular immunity <input type="checkbox"/> Rotavirus contraindicated with severe combined immunodeficiency (SCID).	<input type="checkbox"/> Recent administration of an antibody-containing blood product (MMR, Varicella) <input type="checkbox"/> Student is pregnant. (MMR, Varicella, HPV) <input type="checkbox"/> Thrombocytopenia/thrombocytopenic purpura- now or by history (MMR) <input type="checkbox"/> <b>Rotavirus – altered immunocompetence other than SCID, history of intussusception, chronic GI disease, spina bifida or bladderexstrophy</b>  <b>Any of the conditions below after a previous dose of DTP or DTaP:</b> <input type="checkbox"/> Neurologic disorder – unstable or evolving <input type="checkbox"/> Fever of $\geq 105^\circ$ F ( $40.5^\circ$ C) unexplained by another cause (within 48 hours) <input type="checkbox"/> Seizure or convulsion within 72 hours <input type="checkbox"/> Persistent, inconsolable crying lasting $\geq 3$ (within 48 hours) <input type="checkbox"/> Collapse or shock like state (within 48 hours) <input type="checkbox"/> Guillain-Barré Syndrome (within 6 weeks) <input type="checkbox"/> <b>History of arthus-type hypersensitivity, defer Tetanus-toxoid vaccine for at least 10 years since last dose.</b>

Parent/student has been informed that if an outbreak of vaccine -preventable disease should occur, an exempt student will be excluded from school by the school administrative head for a period of time as determined by the Health Department based on a case-by-case analysis of public health risk.

\_\_\_\_\_  
Healthcare Provider Signature

\_\_\_\_\_  
Date

#### Section 3: For School Official Use Only: Please provide date and signatures and distribute copies as outlined below.

\_\_\_\_\_  
School Nurse Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
School Administrative Head Signature

\_\_\_\_\_  
Date

Note: In accordance with the Rhode Island Department of Health's *Rules and Regulations Pertaining to Immunization and Testing for Communicable Diseases (R23-1-IMM)*, (<http://www.rules.state.ri.us/rules/>), it is the responsibility of the administrative head of the daycare, preschool, school or college to secure compliance with the regulations. The administrative head of the daycare, preschool, school or college shall exclude students who have not received the minimum number of required immunizations and who are not exempt pursuant to the regulations.