



### **2017 Request for Medical Exemption – Influenza Vaccine**

***Applications must be submitted no later than Wednesday, November 1, 2017. You will be notified if your exemption application has been approved or not. If you do not have an active email account, you will be contacted at the phone number you provide below.***

A licensed physician, physician assistant, or nurse practitioner must complete the medical exemption statement and provide his/her information below. Forms completed by the employee only will not be accepted. Submit this completed form to **personnel@uabmw.org** or FAX to **(205) 481-7700**. Please note, all Information will be kept confidential.

#### **Employee Section – complete the following information (print)**

Name (last, first): \_\_\_\_\_

Department: \_\_\_\_\_ Job Title: \_\_\_\_\_

Best Contact Phone Number : \_\_\_\_\_

Email Address: \_\_\_\_\_

I give consent for Employee Health to contact the provider completing this form if additional information or medical records are required. Should your exemption application be approved, Medical West Administration may institute additional controls if the prevalence of influenza within the community rises to a concerning level, including having you wear a surgical mask or procedure mask and/or reassignment of work schedules and duties.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

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#### **Provider Section**

**Physician/Provider Instructions:** Completing this form verifies that different methods of vaccinating against influenza have been considered, and that the following medical contraindication precludes vaccination for influenza. Guidance for medical exemptions for influenza vaccination can be obtained from the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP), available in the Centers for Disease Control and Prevention publication, Morbidity and Mortality weekly report:

[www.cdc.gov/flu/professionals/acip/index.htm](http://www.cdc.gov/flu/professionals/acip/index.htm)

#### ***The following are not considered contraindications to influenza vaccination:***

- Minor acute illness (e.g. diarrhea and minor upper respiratory tract illnesses, including otitis media)
- Mild to moderate local reactions and/or low-grade moderate fever following a prior dose of the vaccine
- Sensitivity to a vaccine component (e.g. upset stomach, soreness, redness, itching, swelling at the injection site)
- Current antimicrobial therapy (taking prescription anti-influenza therapy is only a temporary contraindication for the live attenuated influenza vaccine [LAI])
- Disease exposure or convalescence
- Pregnant or breastfeeding
- Pregnant or immunosuppressed person in the household

**Document the patient's medical condition and contraindication to receiving the influenza vaccine. If more space is needed, attach additional sheets to this form. Attach medical records as appropriate.**

- History of Guillain-Barré syndrome, with documentation in the medical record
- Anaphylactic reaction due to components of flu vaccine (describe the reaction or provide details in the space below)
- Other medical contraindication (be specific and describe in detail below)

Date of reaction checked above: \_\_\_\_\_

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Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Practice Name: \_\_\_\_\_

Practice Telephone Number: \_\_\_\_\_

**OFFICE USE ONLY**

Request is:  Approved  Denied

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Comments:

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