COVID 19 VACCINE MEDICAL EXEMPTION FORM

Name ID#	Date of Birth:
Name of Parent/Guardian (if under 18): *first / middle / last*	Primary Phone:
Patient/Parent Home Address: *address 1* *address 2* *city* *state* *zip*	
Patient/Parent Email Address:	

Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP)/CDC, available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html or https://www.cdc.gov/vaccines/covid-19/index.html or https://redbook.solutions.aap.org/redbook.aspx

Please check the website to ensure that you are reviewing the most recent CDC/ACIP information. Please note that the presence of a moderate to severe acute illness with or without fever is a precaution to administration of all vaccines However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication.

Table 1. ACIP Contraindications and Precautions to Vaccination for Mandatory Vaccines

Vaccine	Exemption Length	ACIP Contraindications and Precautions
COVID19 Vaccine	☐ Temporary through: _____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Other (explain below)

Vaccine	Exemption Length	CDC/ACIP Contraindications and Precautions
Other. Please explain fully.		

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 nurse licensed in a jurisdiction of the United States.

By signing below, I affirm that I have reviewed the current CDC/ACIP Contraindications and Precautions and affirm that the stated contraindication(s)/precaution(s) is enumerated by the CDC/ACIP and consistent with established national standards for vaccination practices. I understand that I might be required to submit supporting medical documentation

Healthcare Provider Name (please print): _____ Specialty: _____

NPI Number: _____ License Number: _____ State of Licensure: _____

Phone: _____ Fax: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ Date: _____