TN Department of Health

Communicable and Environmental Diseases and Emergency Preparedness
Vaccine-Preventable Diseases and Immunization Program (VPDIP)

MEDICAL EXEMPTION FROM IMMUNIZATION

This form must be completed by a physician (MD/DO) or Tennessee Department of Health Public Health Nurse (PHN) licensed in the State of Tennessee to document a true medical contraindication/precaution to an immunization(s). This document may be accepted by agencies that require proof of medical exemption.

Tenn. Comp. Rules and Regs. 1200-14-01-.29(18)(a) provides for an exemption where a determination is made that a particular vaccine is contraindicated for one of the following reasons: 1. The individual meets the criteria for contraindication set forth in the manufacturer's vaccine package insert; or 2. The individual meets the criteria for contraindication published by the U.S. Centers for Disease Control or the ACIP; 3. In the best professional judgment of the physician, based upon the individual's medical condition and history, the risk of medical harm from the vaccine outweighs the potential benefit. An individual who has been exempt from a particular vaccination **must comply with immunization requirements for any vaccine from which he/she has not been exempt**. See *Tenn. Comp. Rules and Regs. 1200-14-1-.29-(18)(b), T.C.A. Section 68-5-106(b)* states that **any physician fraudulently giving a certificate of sickness or of vaccination to prevent vaccination commits a Class C misdemeanor.**

Patient Name (*please print*): _____ DOB: ____/____/____

Parent/Guardian Name: _____ Parent/Guardian Phone: (____) ____-____

Patient/Parent Address: _____ County: _____

Child Care/School/College/University: _____

Medical contraindications and precautions for immunizations are described in the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP), available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html#t-02.

A **contraindication** is a condition in a recipient that increases the risk for a serious adverse reaction. A vaccine will not be administered when a contraindication is present. A **precaution** is a condition in a recipient that **might** increase the risk for a serious adverse reaction or that **might** compromise the ability of the vaccine to produce immunity. Under normal conditions, vaccinations should be **deferred** when a precaution is present and administered after the precaution resolves.

Vaccine	Check all true contraindications and precautions that apply to this patient.
☐ **Diphtheria, Tetanus, Pertussis (DTaP)** ☐ **Tetanus, Diphtheria, Pertussis (Tdap)** ☐ **Tetanus, Diphtheria (DT, Td)**	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. ☐ For pertussis-containing vaccines: encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizure) not attributable to another identifiable cause within 7 days of administration of DTaP or DTP (for DTaP); or of previous dose of DTaP, DTP, or Tdap (for Tdap). ☐ These published contraindications are not true for this patient, but it is my best professional judgement that based upon the individual's medical condition and history, the risk of medical harm from the vaccine outweighs the potential benefit. **Precautions** ☐ Moderate or severe acute illness with or without fever. Defer vaccination until symptoms resolve. ☐ Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus-toxoid-containing vaccine. ☐ History of arthus-type hypersensitivity reaction after a previous dose of a tetanus or diphtheria-toxoid-containing vaccine. Defer until at least 10 years have elapsed since the last tetanus-toxoid-containing vaccine. ☐ For pertussis-containing vaccines: progressive or unstable neurologic disorder (including infantile spasms for DTaP), uncontrolled seizures, or progressive encephalopathy. Defer until a treatment regimen has been established and the condition has stabilized. ***Date Exemption Ends:** _____ **MD/DO/PHN Initials:** _____
☐ **Measles, Mumps, Rubella (MMR)**	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. ☐ Known severe immunodeficiency (e.g., congenital immunodeficiency, malignancy, chemotherapy, long-term immunosuppressive therapy (e.g., ≥ 2 weeks of daily steroid therapy of ≥20 mg or 2 mg/kg body weight; or human immunodeficiency virus (HIV) infection with CD4+ T-lymphocyte count ≤ 15%). ☐ Family history of altered immunocompetence (e.g., first degree relative (biological parent or sibling) unless the immune competence of the potential vaccine recipient has been substantiated clinically or verified by a laboratory). ☐ Pregnancy. ☐ These published contraindications are not true for this patient, but it is my best professional judgement that based upon the individual's medical condition and history, the risk of medical harm from the vaccine outweighs the potential benefit. **Precautions** ☐ Moderate or severe acute illness with or without fever. Defer vaccination until symptoms resolve. ☐ Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product). ☐ History of thrombocytopenia or thrombocytopenic purpura. ☐ Need for tuberculin skin testing or Interferon-Gamma Release Assay (IGRA) testing; postpone testing until ≥ 4 weeks after vaccination. MMR can be administered in the same day as TB skin testing or IRA testing. (Measles vaccine might suppress tuberculin reactivity temporarily). ***Date Exemption Ends:** _____ **MD/DO/PHN Initials:** _____
☐ **Varicella (Var)**	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. ☐ Known severe immunodeficiency (e.g., congenital immunodeficiency, malignancy, chemotherapy, long-term immunosuppressive therapy (e.g., ≥ 2 weeks of daily receipt of ≥20 mg or 2 mg/kg body weight of prednisone or equivalent) or human immunodeficiency virus (HIV) infection with CD4+ T-lymphocyte count ≤15%. ☐ Pregnancy. ☐ These published contraindications are not true for this patient, but it is my best professional judgement that based upon the individual's medical condition and history, the risk of medical harm from the vaccine outweighs the potential benefit. **Precautions**

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Varicella (Var) cont'd.	☐ Moderate or severe acute illness with or without fever. Defer vaccination until symptoms resolve. ☐ Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product). ☐ Receipt of specific antivirals (e.g., acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination. Avoid use of these antivirals for 14 days after vaccination. Avoid use of aspirin or aspirin containing products for 6 weeks after vaccination. ***Date Exemption Ends:** _____ **MD/DO/PHN Initials:** _____
☐ **Inactivated Polio Virus (IPV)**	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. ☐ These published contraindications are not true for this patient, but it is my best professional judgement that based upon the individual's medical condition and history, the risk of medical harm from the vaccine outweighs the potential benefit. **Precautions** ☐ Moderate or severe acute illness with or without fever. Defer vaccination until symptoms resolve. ☐ Pregnancy. ***Date Exemption Ends:** _____ **MD/DO/PHN Initials:** _____
☐ **Hepatitis B (Hep B)**	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. ☐ These published contraindications are not true for this patient, but it is my best professional judgement that based upon the individual's medical condition and history, the risk of medical harm from the vaccine outweighs the potential benefit. **Precautions** ☐ Moderate or severe acute illness with or without fever. Defer vaccination until symptoms resolve. ***Date Exemption Ends:** _____ **MD/DO/PHN Initials:** _____
☐ **Haemophilus Influenza type B (HIB)**	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. ☐ These published contraindications are not true for this patient, but it is my best professional judgement that based upon the individual's medical condition and history, the risk of medical harm from the vaccine outweighs the potential benefit. **Precautions** ☐ Moderate or severe acute illness with or without fever. Defer vaccination until symptoms resolve. ***Date Exemption Ends:** _____ **MD/DO/PHN Initials:** _____
☐ **Pneumococcal (PCV13)**	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component (any diphtheria-toxoid-containing vaccine), including yeast. ☐ These published contraindications are not true for this patient, but it is my best professional judgement that based upon the individual's medical condition and history, the risk of medical harm from the vaccine outweighs the potential benefit. **Precautions** ☐ Moderate or severe acute illness with or without fever. Defer vaccination until symptoms resolve. ***Date Exemption Ends:** _____ **MD/DO/PHN Initials:** _____
☐ **Meningococcal (MCV4)**	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. ☐ These published contraindications are not true for this patient, but it is my best professional judgement that based upon the individual's medical condition and history, the risk of medical harm from the vaccine outweighs the potential benefit. **Precautions** ☐ Moderate or severe acute illness with or without fever. Defer vaccination until symptoms resolve. ***Date Exemption Ends:** _____ **MD/DO/PHN Initials:** _____
☐ **Meningococcal (MenB)**	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. ☐ Pregnancy. ☐ These published contraindications are not true for this patient, but it is my best professional judgement that, based upon the individual's medical condition and history, the risk of medical harm from the vaccine outweighs the potential benefit. **Precautions** ☐ Moderate or severe acute illness with or without fever. Defer vaccination until symptoms resolve. ***Date Exemption Ends:** _____ **MD/DO/PHN Initials:** _____

***This document will not be accepted unless the "Date Exemption Ends" line is completed. A physician (MD/DO) licensed to practice medicine in the State of Tennessee or a Tennessee Department of Health Public Health Nurse (PHN) must complete and sign this form.**

Facility/Practice Name: _____ Facility/Practice Phone: (____) ____-____

Facility/Practice Address: _____ County: _____

TN Provider Name (*please print*): _____ Credentials (*circle one*): MD DO PHN

TN Provider Signature: _____ Date: ____/____/____

Provider Instructions

1. Complete and sign this form.
2. **Attach a copy of the most current immunization record.**
3. Retain a copy for the patient's medical record.
4. Return the original to the individual requesting this form.
5. Patient vaccinations should be reported in the Tennessee Immunization Information System (TennIIS) at https://www.tennesseeiis.gov.