DENISON

Vaccine Medical Exemption Application

STUDENT SECTION

Name _____
Last Name First Name Middle Initial

Date of Birth _____ **D#** _____
Month/Day/Year

Best Phone Number _____ **Email Address:** _____

Students should submit this completed form through the Denison University's Enrollment Portal (same location where the form was retrieved). **For Fall Semester, form is due by May 20 and for Spring Semester form is due by Dec 15.** Information will be kept confidential in your medical record. After review you will receive an email via your Denison email account.

A licensed physician, PA, or NP must complete the medical exemption statement and provide their contact information below. The medical provider CANNOT be a relative or close family friend. Forms completed by the student will not be accepted.

Physician/Medical Provider Instructions: This form must be completed in its entirety, including where substantiating descriptions or additional information is requested.

Guidance about contraindications can be obtained from the Center for Disease Control & Prevention Vaccine Recommendations & Guidelines of the ACIP (https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html)

Vaccine Specific Contraindications

VACCINE		CONTRAINDICATION
DT, Td	☐	Severe Allergic Reaction (anaphylaxis) after a previous dose or to a vaccine component
DTaP/Tdap	☐	Severe Allergic Reaction (anaphylaxis) after a previous dose or to a vaccine component
	☐	Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures), not attributable to another identifiable cause, within 7 days of administration of previous dose of DTP or DTaP
Hepatitis B	☐	Severe Allergic Reaction (anaphylaxis) after a previous dose or to a vaccine component
	☐	Hypersensitivity to yeast
MenACWY	☐	Severe Allergic Reaction (anaphylaxis) after a previous dose or to a vaccine component
MMR	☐	Severe Allergic Reaction (anaphylaxis) after a previous dose or to a vaccine component
	☐	Known severe immunodeficiency (describe)
	☐	Family history of altered immunocompetence (describe)
Varicella	☐	Severe Allergic Reaction (anaphylaxis) after a previous dose or to a vaccine component
	☐	Pregnancy
	☐	Family history of altered immunocompetence (family history of congenital or hereditary immunodeficiency in first-degree relatives)

ATTENTION: For any checkbox(es) above, please provide a description detailing the identified contraindication (e.g., description, nature, severity, treatment dates, including any hospitalization)

Other Medical Contraindications (Must list vaccine(s) and contraindications individually - continue on back if necessary).	
Vaccine	**Indicate Specific Contraindication** (including description and dates of adverse events, severity; hospitalizations; and attach any supporting documentation)

Please indicate the duration of the medical exemption, and if and when the vaccine can be safely administered.
Exemption can last for a maximum of one (1) year, and a new form must be completed annually if medical exemption still applies.

☐ Medical exemption is indefinite (which will apply for one (1) year from today's date).
☐ Medical exemption is temporary (<1 year), and resolution is anticipated by ___/___/_____
☐ Medical exemption is pregnancy, and Estimated Date of Confinement is ___/___/_____

Provider Name _____ Provider License # _____
Office Address _____ Telephone # _____
_____ Fax # _____

Provider Signature _____ Date _____/_____/_____