Medical Exemption Request – Seasonal Influenza Vaccine

This section to be completed by the individual requesting a medical exemption(Please complete all sections)

Name _____ Date of birth _____

Home address: _____ Contact phone number

I am a(n): ☐employee ☐student ☐ contractor ☐vendor ☐volunteer ☐ PT ☐FT ☐ PRN

Employee/Contractor ID Number: Department #: Leader name:

I request a medical exemption from the seasonal influenza vaccination. I understand that this form must be completed and returned to the Flu exemption mailbox by the deadline of I also understand that if I am granted an exemption, I must wear a surgical mask at all times when I am in direct contact with, or within 6 feet of, any patient for the duration of the flu season. Failure to do so will result in disciplinary action up to and including termination. If I am not granted an exemption, I must receive the vaccination as required by policy.

Individual's signature _____ Date _____

This section to be completed by the physician of the individual requesting a medical exemption

Dear Physician,

Influenza vaccination is the most effective method of controlling the spread of influenza, and the Advisory Committee on Immunization Practices (ACIP) strongly recommends that all health care workers receive the vaccine. In keeping with our commitment to patient safety and *First Do No Harm*, Novant Health now requires its employees, physicians, allied health professionals, students, contractors, vendors and volunteers to receive a seasonal influenza vaccination.

Your patient (named above) has requested a medical exemption. Medical exemptions are allowed based on recognized contraindications. Please complete the bottom portion of this form. If you have questions, please contact your local employee occupational health office for assistance.

Sincerely yours,

David H. Priest, MD, MPH, FIDSA
Senior Vice President, Chief Safety, Quality, and Epidemiology Officer
Novant Health

Physician Certification of Contraindication

I certify that my patient should not be vaccinated against influenza because he/she has one of the following recognized contraindications:

☐ **Documented anaphylactic allergic reaction or other severe adverse effect to the influenza vaccine** – *e.g.,* cardiovascular changes, respiratory distress, or history of treatment with epinephrine or other emergency medical attention to control symptoms. Generally does not include gastro-intestinal symptoms as the sole presentation of allergy.

Describe the specific reaction – _____

_____

_____

☐ **Documented allergy to a component of the vaccine** – does not include allergic reaction to egg (egg-free vaccines are available), sore arm, local reaction or subsequent respiratory tract infection

Describe the specific reaction – _____

_____

☐ **Patient has had history of Guillain-Barré (or Guillain-Barré-like) syndrome**

Physician signature (required) _____ Date _____

Physician printed name _____ Phone # _____

Send completed form to the "Flu Exemptions" mailbox or RZG648@novanthealth.org