



VACCINE MEDICAL EXEMPTION

State Form 54648 (4-11)
Indiana State Department of Health, Immunization Division

INSTRUCTIONS: 1. This form for any child in grades K – 12 who is unable to receive a vaccine required for school entry due to a medical contraindication.
2. Complete and sign form. Submitted to school as proof of exemption from required immunization.

Patient Name _____ Date of Birth (month/day/year) _____
Parent/Guardian Name _____ Relationship _____
Street Address _____
City _____ ZIP Code _____ Telephone Number _____

General Contraindications to All Vaccines (Vaccine should **not** be given.)

Severe allergic reaction (e.g., anaphylaxis) after a previous vaccine dose or to a vaccine component

- | | | |
|--|--|---|
| <input type="checkbox"/> Hepatitis B (Hep B) | <input type="checkbox"/> Inactivated poliovirus (IPV) | <input type="checkbox"/> Meningococcal, conjugate (MCV4) |
| <input type="checkbox"/> Diphtheria, tetanus, pertussis (DTaP, Tdap) | <input type="checkbox"/> Measles, mumps, rubella (MMR) | <input type="checkbox"/> or Meningococcal, polysaccharide (MPSV4) |
| <input type="checkbox"/> Tetanus, diphtheria (DT, Td) | <input type="checkbox"/> Varicella (Var) | |

Which vaccine or vaccine component caused reaction? _____

Type of Clinical Reaction & Date (month, day year) _____

Vaccine Specific Contraindications (Vaccine should **not** be given.)

DTaP or Tdap	<input type="checkbox"/> Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within seven (7) days of administration of previous dose of DTP or DTaP
MMR	<input type="checkbox"/> Pregnancy Estimated Date of Confinement (EDC): _____ (month, day year) <input type="checkbox"/> Known severe immunodeficiency (e.g., hematologic and solid tumors; receiving chemotherapy; congenital immunodeficiency; long term immunosuppressive therapy; or patients with HIV infection who are severely immunocompromised)
Varicella	<input type="checkbox"/> Pregnancy Estimated Date of Confinement (EDC): _____ (month, day year) <input type="checkbox"/> Substantial suppression of cellular immunity

Vaccine Specific Precautions (Vaccine may be given or held depending on clinical situation.)

DTaP or Tdap	<input type="checkbox"/> Guillan-Barre syndrome (GBS) within six (6) weeks after a previous dose of tetanus-containing vaccine <input type="checkbox"/> History of Arthus-type hypersensitivity reaction following a previous dose of tetanus and/or diphtheria toxoid-containing vaccine: defer vaccination until at least ten (10) years have elapsed since the previous dose <input type="checkbox"/> Progressive or unstable neurologic disorder, uncontrolled seizures or progressive encephalopathy: defer vaccination with DTaP or Tdap until a treatment regimen has been established and the condition has stabilized
DTaP	<input type="checkbox"/> Temperature of $\geq 105^{\circ}\text{F}$ ($\geq 40.5^{\circ}\text{C}$) within forty-eight (48) hours after vaccination with a previous dose of DTP/DTaP <input type="checkbox"/> Collapse and shock-like state (i.e.: hypotonic hyporesponsive episode) within forty-eight (48) hours after previous dose of DTP/DTaP <input type="checkbox"/> Seizure or convulsion within three (3) days after receiving a previous dose of DTP/DTaP <input type="checkbox"/> Persistent, inconsolable crying lasting three (3) or more hours within forty-eight (48) hours after a previous dose of DTP/DTaP
MMR	<input type="checkbox"/> Recent (within eleven (11) months) receipt of antibody-containing blood product (interval depends on product) <input type="checkbox"/> History of thrombocytopenia or thrombocytopenic purpura
Varicella	<input type="checkbox"/> Recent (within eleven (11) months) receipt of antibody-containing blood product (interval depends on product) <input type="checkbox"/> Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) twenty-four (24) hours before vaccination; if possible, delay resumption of these antiviral drugs for fourteen (14) days after vaccination

Other Medical Contraindication (Must list vaccine(s) and contraindications individually – continue on back if necessary.)

Vaccine	Specific Contraindication

Please indicate the duration of the medical exemption, and if and when 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 permanent, and 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 (EDC) is ____/____/____

Physician Name _____ Physician License Number _____

Office Address _____ Telephone _____

Physician Signature _____ Date (month, day year) _____