

Influenza Vaccine

Name _____ Date of Birth (DOB) _____

Address _____

Name of Health Care Facility _____

Medical exemptions for influenza vaccination should be based on contraindications and precautions determined by the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP), Public Health Services, U.S. Department of Health and Human Services, published in the Centers for Disease Control and Prevention publication, the Morbidity and Mortality Weekly Report.

Medical contraindications and precautions recognized by the Advisory Committee on Immunization Practices (ACIP) will be permitted as exemptions for immunization. These ACIP contraindications and precautions are to guide determinations made by individual practitioners to the existence of a medical exemption.

Criteria for Exemption

<input type="checkbox"/>	Contraindications <ul style="list-style-type: none">• Severe allergic reaction after a previous dose or to a vaccine component (e.g., eggs).
<input type="checkbox"/>	Precautions: <ul style="list-style-type: none">• Current moderate or severe acute illness with or without fever (until symptoms have abated).• History of Guillain Barré Syndrome within 6 weeks of a previous influenza vaccination.

Instructions <ol style="list-style-type: none">1. Complete information (name, DOB etc.).2. Check applicable exemption(s).3. Complete date exemption ends and medical provider information.4. Retain copy for file. Return original to person requesting form. For Questions Call (518)473-4437	Date exemption ends _____ Name _____ Name of New York State licensed physician, physician assistant, nurse practitioner, nurse-midwives or licensed midwife (<i>please print</i>). Address _____ Telephone _____ Signature _____ Date _____ Signature of New York State licensed physician, physician assistant, nurse practitioner, nurse-midwives or licensed midwife.
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