DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Immunization Program

# School Vaccination Medical Exemption Form

The School Vaccination Medical Exemption Form is the official Division of Public Health (DPH) document to be completed by a currently licensed physician, advanced practice nurse, nurse practitioner, or physician's assistant to exempt a child from childcare or school immunization requirements. The clinician certifies that due to the child's health or medical condition, the child may be adversely affected on a temporary or permanent basis by one or more of the required vaccines. The signed medical exemption statement verifying true contraindications/precautions is submitted to and accepted by Delaware schools, child care programs, and other agencies that require proof of immunization. The signed form does not require further approval from the Delaware Division of Public Health.

For exemption of medical conditions not listed on this form, the clinician must submit the *Supplemental School Vaccine Medical Exemption Form* to DPH for approval.

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 exists.

A ***precaution*** is a condition in a recipient that might increase the risk for a serious adverse reaction or compromise the ability of the vaccine to produce immunity. Under normal conditions, vaccinations should be deferred when a precaution is present. Indicate if an exemption is permanent or temporary.

*Vaccine medical contraindications are determined by the Advisory Committee on Immunization Practices (ACIP).*

Please return the form to:

School: _____

Address: _____

Fax Number: _____

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Immunization Program

Please indicate whether the exemption is: ☐ **permanent** or ☐ **temporary**
For ***temporary*** exemption, list the date the exemption ends: ____/_____/_____

| Vaccine | Check if Applicable | | Contraindications/Precautions |
|---|---|---|---|
| **DTaP** | **Permanent** | **Temporary** | **Contraindications** |
| | ☐ | ☐ | • Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component |
| | ☐ | ☐ | • Encephalopathy within seven days after receipt of previous dose of DTP or DTaP |
| | | | **Precautions** |
| | ☐ | ☐ | • Progressive neurologic disorder, including infantile, spasms, uncontrolled epilepsy, progressive encephalopathy: defer DTaP until neurologic status clarified and stabilized |
| | ☐ | ☐ | • Fever greater than 104.9°F (40.5°C) within 48 hours after vaccination of previous dose of DTP/DTaP |
| | ☐ | ☐ | • Guillain-Barre syndrome within 6 weeks after a previous dose of tetanus toxoid-containing vaccine |
| | ☐ | ☐ | • Hypotonic-hyporesponsive episodes within 48 hours after vaccination of previous dose of DTP or DTaP |
| | ☐ | ☐ | • Seizure within 72 hours after vaccination of previous dose of DTP or DTaP |
| | ☐ | ☐ | • Persistent, inconsolable crying lasting three hours or more 48 hours after receiving a previous dose of DTP or DTaP |
| | ☐ | ☐ | • Moderate or severe acute illness with or without fever |
| | ☐ | ☐ | • History of arthus-type hypersensitivity reactions after a previous dose of tetanus or diphtheria toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid containing vaccine |
| **Tdap** | | | **Contraindications** |
| | ☐ | ☐ | • Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component |
| | ☐ | ☐ | • Encephalopathy within seven days after receipt of previous dose of DTP or DTaP |
| | | | **Precautions** |
| | ☐ | ☐ | • Progressive neurologic disorder, uncontrolled seizures or progressive encephalopathy; defer vaccination until treatment regimen is established and condition stabilized. |
| | ☐ | ☐ | • Moderate or severe acute illness with or without fever |
| | ☐ | ☐ | • Guillain-Barre syndrome within 6 weeks after a previous dose of tetanus toxoid-containing vaccine |
| | ☐ | ☐ | • History of arthus-type hypersensitivity reactions after a previous dose of tetanus or diphtheria toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid containing vaccine |
| **DT/Td** | | | **Contraindications** |
| | ☐ | ☐ | • Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component |
| | | | **Precautions** |
| | ☐ | ☐ | • Guillain-Barre syndrome within 6 weeks after a previous dose of tetanus toxoid-containing vaccine |
| | ☐ | ☐ | • Moderate or severe acute illness with or without fever |
| | ☐ | ☐ | • History of arthus-type hypersensitivity reactions after a previous dose of tetanus or diphtheria toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid containing vaccine |
| Varicella | | | **Contraindications** |
| | ☐ | ☐ | • Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component |
| | ☐ | ☐ | • Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, primary or acquired immunodeficiency, long-term immunosuppressive therapy, or patients with HIV infection who are severely immunocompromised) |
| | ☐ | ☐ | • Pregnancy |
| | | | **Precautions** |
| | ☐ | ☐ | • Moderate or severe acute illness with or without fever |
| | ☐ | ☐ | • Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product) |
| | ☐ | ☐ | • Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination; if possible, delay administration of these antiviral drugs for 14 days after vaccination. |
| | ☐ | ☐ | • **Documented** past history of Varicella disease. |
| **IPV** | | | **Contraindications** |
| | ☐ | ☐ | • Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component |
| | | | **Precautions** |
| | ☐ | ☐ | • Pregnancy |
| | ☐ | ☐ | • Moderate or severe acute illness with or without fever |

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Immunization Program

| | | | |
|---|---|---|---|
| **Hepatitis B** | | | **Contraindications** |
| | ☐ | ☐ | • Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component |
| | | | **Precautions** |
| | ☐ | ☐ | • Infant weighing <2,000 grams if mother has documented hepatitis B surface antigen (HbsAg)-negative at the time of the infant's birth |
| | ☐ | ☐ | • Moderate or severe acute illness with or without fever |
| **MMR** | | | **Contraindications** |
| | ☐ | ☐ | • Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component |
| | ☐ | ☐ | • Pregnancy |
| | ☐ | ☐ | • Known severe immunodeficiency (e.g., hematologic and solid tumors, or severely symptomatic infection) |
| | | | **Precautions** |
| | ☐ | ☐ | • Recent (11 months) receipt of antibody-containing blood product (specific interval depends on product) |
| | ☐ | ☐ | • History of thrombocytopenia or thrombocytopenic purpura |
| | ☐ | ☐ | • Moderate or severe acute illness with or without fever |
| **Meningococcal** | | | **Contraindications** |
| | ☐ | ☐ | • Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component |
| | | | **Precautions** |
| | ☐ | ☐ | • Moderate or severe acute illness with or without fever |
| | ☐ | ☐ | • Receipt of specific antivirals (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination; if possible, delay administration of these antiviral drugs for 14 days after vaccination. |
| **Haemophilus influenza type b (Hib)** | | | **Contraindications** |
| | ☐ | ☐ | • Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component |
| | ☐ | ☐ | • Age younger than 6 weeks |
| | ☐ | ☐ | • Moderate or severe acute illness with or without fever |
| **Pneumococcal Disease** | | | **Contraindications** |
| | ☐ | ☐ | • Severe allergic reaction (e.g., anaphylaxis) after a previous dose of PCV7 or PCV13 or to a vaccine component, including to any vaccine containing diphtheria toxoid |
| | ☐ | ☐ | • For PPSV23, severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component |
| | | | **Precautions** |
| | ☐ | ☐ | • Moderate or severe acute illness with or without fever |

I am aware that in the event that the Division of Public Health (DPH) declares an outbreak of a vaccine preventable disease, or if in the estimation of DPH, my child has had, or is at risk of having an exposure to a vaccine preventable disease, my child shall be temporarily excluded from attendance at the childcare and/or school until the risk period ends, which may be three weeks or longer. My child shall be authorized to return to school once approved by DPH.

Name of Patient _____ DOB ___/___/_____

Name of Parent/Guardian _____

Signature (Patient/Parent) _____

*Provider Information:*

Clinician Name (print) _____ MD/DO/APRN/PA

License #: _____

Signature _____ Date____/____/_____

Address _____

Phone # _____