MESSIAH UNIVERSITY

MEDICAL EXEMPTION STATEMENT

To be completed by MD, DO, CRNP or PA-C: Please mark the true contraindications/ precautions that apply to this patient, then sign/date the form. The signed/dated Medical Exemption Statement verifying true contraindications/precautions is then submitted to and verified by the Medical Director at the Messiah University Engle Health Center.

*****ATTACH A COPY OF THE MOST CURRENT IMMUNIZATION RECORD*****

TRUE CONTRAINDICATIONS AND PRECAUTIONS

Vaccine	X	
General for all Vaccines	☐ ☐ ☐ ☐	**Contraindications** • Serious allergic reaction (i.e. anaphylaxis) after a previous vaccine dose: document vaccine _____ • Serious allergic reaction (i.e. anaphylaxis) to a vaccine component _____ • Document type of reaction_____ **Precautions** • Moderate or severe acute illness with or without fever _____
MMR	☐ ☐ ☐ ☐ ☐ ☐	**Contraindications** • Severe allergic reaction after a previous dose or to a vaccine component • Pregnancy • Known severe immunodeficiency _____ **Precautions** • Recent (≤ 11 months) receipt of antibody-containing blood product • History of thrombocytopenia or thrombocytopenic purpura • Moderate or severe acute illness with or without fever
Tdap	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	**Contraindications** • Severe allergic reaction after a previous dose or to a vaccine component • Severe allergy to latex • Encephalopathy within seven days after receipt of a previous dose of DTP or DTaP **Precautions** • Guillian-Barré syndrome ≤ weeks after a previous dose of tetanus toxoid-containing vaccine • Progressive neurologic disorder, including progressive encephalopathy, or uncontrolled epilepsy, until the condition has stabilized • Arthus reaction following a previous dose of any vaccine containing tetanus toxoid or diphtheria • Moderate or severe acute illness with or without fever • Pregnancy

COVID-19	☐ ☐ ☐ ☐	**Contraindications** • Allergic reaction to a previous mRNA vaccine • Allergic to polyethylene glycol (PEG) or polysorbate **Precautions** • Thrombosis with Thrombocytopenia (J&J Vaccine only) • Known severe immunodeficiency _____

Signature of MD/DO/CRNP/PA-C _____

Name of Health Care Provider (please print) _____

Date signed _____

Address _____

Phone _____

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Student/Parental Statement: I understand that waiving immunizations even for medical reasons subjects me to the possible exclusion from campus in the event of an outbreak for which immunization is required.

Student signature _____ Date _____

Parent signature _____ Date _____

(required if student under 18)