Medical/Allergy Exemption Request Form – Part B

To be completed by requestor's personal health care provider.

Patient Name:_____________________________________ Date of Birth: _________________

The VUMC influenza vaccination program requires all VUMC team members to receive an annual influenza vaccine. Your patient is requesting a medical exemption from receiving the influenza vaccination. Medical exemptions are granted for recognized contraindications.

Guidance for medical contraindications can be obtained from the Centers for Disease Control and Prevention at http://www.cdc.gov/flu/protect/vaccine/index.htm

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Please clarify your patient's contraindication to the influenza vaccine:

☐ **Previous systemic reaction to influenza vaccine not due to egg allergy (e.g. hives, difficulty breathing, swelling of tongue or lips)**

Description of reaction: ____

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Date of vaccine: _____________

How long after vaccination did symptoms begin?_________________

☐ **Severe Egg Allergy**

Please advise the patient of current CDC recommendations for influenza vaccination in patients with egg allergy. For severe egg allergy, VUMC provides egg-free recombinant influenza vaccine (RIV) upon request. Exemptions will not be granted for egg allergy.

☐ **History of Guillain Barré Syndrome**

Date Patient had GBS:________________

☐ **Other Medical Contraindication: ____**

Description of reaction, if applicable: ____

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Date of reaction, if applicable: __________________

To a responsible degree of medical certainty, it is my opinion that my patient referenced above has the influenza vaccine contraindication as identified.

Provider's Signature_______________________________________ Date ____________________

Provider's Name (printed)___________________________________

Address____Phone____________________________

Fax this document to 615-936-0966 or
submit electronically at https://healthandwellness.vanderbilt.edu/submit-records/