



Lejeune - New River Child and Youth Programs

**Immunization Medical Exemption Form**

**Purpose:** To provide licensed medical providers a mechanism to document a true medical contraindications and/or precautions to particular immunization(s), for a child enrolled in a Child & Youth Program Child Development Center or Family Child Care Program. Policies shall be implemented to ensure that appropriate services are implemented for children, youth and teens with special needs. Such policies shall meet the requirement of the Rehabilitation Acts and the Department of Defence Directive 1020.1, Non-Discrimination on the Basis of Handicap in Programs and Activities Assisted or Conducted by the Department of Defense.

**Routine Uses:** The provided information will be used to document medical contraindications and/or precautions related to immunizations required for participation in Child & Youth Programs; per MCO 1710.30.

**Disclosure:** Disclosure of information is voluntary. However, if information is not provided, individuals may not be allowed to participate in the Child & Youth Program, per MCO 1710.30.

**General Information (completed by parent/guardian)**

Child's Name:		Date of Birth:	
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Sponsor's Name:	
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Medical contraindications and precautions for immunizations are described in the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP), available at <http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm>.

**BELOW TO BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL**

VACCINE	CHECK ALL TRUE CONTRAINDICATIONS & PRECAUTIONS THAT APPLY TO THIS PATENT
<input type="checkbox"/> <b>Influenza</b>	<p><b>Contraindications:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.</li> <li><input type="checkbox"/> Children who are less than 6 months of age.</li> </ul> <p><b>Precautions:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Moderate to severe acute illness with or without fever.</li> </ul>
<input type="checkbox"/> <b>Hepatitis B</b> (HEP-B)	<p><b>Contraindications:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.</li> </ul> <p><b>Precautions:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Moderate to severe acute illness with or without fever.</li> <li><input type="checkbox"/> Infant weighing less than 2000 grams (4lbs 6.4 oz), if mother is documented Hepatitis B surface antigen negative at the time of the infants birth.</li> </ul>
<input type="checkbox"/> <b>Inactivated Polio Virus</b> (IPV)	<p><b>Contraindications:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.</li> </ul> <p><b>Precautions:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Moderate to severe acute illness with or without fever.</li> <li><input type="checkbox"/> Pregnancy</li> </ul>
<input type="checkbox"/> <b>Haemophilus Influenza</b> Type B (HIB)	<p><b>Contraindications:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.</li> <li><input type="checkbox"/> Infant less than 6 weeks old</li> </ul> <p><b>Precautions:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Moderate to severe acute illness with or without fever.</li> </ul>
<input type="checkbox"/> <b>Pneumococcal</b> (PCV13)	<p><b>Contraindications:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.</li> </ul> <p><b>Precautions:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Moderate to severe acute illness with or without fever.</li> </ul>
<input type="checkbox"/> <b>Hepatitis A</b> (HEP-A)	<p><b>Contraindications:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component, including any diphtheria toxoid-containing vaccine</li> </ul> <p><b>Precautions:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Moderate to severe acute illness with or without fever.</li> </ul>

<input type="checkbox"/> <b>Diphtheria, Tetanus, Pertussis (DTaP)</b>  <input type="checkbox"/> <b>Tetanus, Diphtheria, Pertussis (Tdap)</b>  <input type="checkbox"/> <b>Tetanus, Diphtheria (DT, Td)</b>	<p><b>Contraindications:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.</li> <li><input type="checkbox"/> For pertussis-containing vaccines: encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizure) not attributable to another identifiable cause within 7 days of administration of the DTaP or DTP (for DTaP); or of previous dose of DTaP, DTP, or Tdap.</li> </ul> <p><b>Precautions:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Moderate to severe acute illness with or without fever.</li> <li><input type="checkbox"/> Guillian-Barre syndrome (GBS) within 6 weeks after a previous dose of tetanus toxoid containing vaccine</li> <li><input type="checkbox"/> History of arthus-type hypersensitivity reaction a dose of a tetanus or diphtheria toxoid containing vaccine; defer until at least 10yrs have elapsed since the last tetanus toxoid containing vaccine</li> <li><input type="checkbox"/> For pertussis containing vaccines; progressive or unstable neurologic disorder (including infantile spasms for DTaP), uncontrolled seizures, or progressive encephalopathy, until a treatment regimen is established and the condition has stabilized.</li> </ul> <p><b>Additional Precautions that only apply to DTaP</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Temperature of 105° or higher, within 48 hours after a previous dose of DTP/DTaP</li> <li><input type="checkbox"/> Collapse or shock like state (e.g., hypotonic, hyporesponsive episode) within 48hrs after receiving a previous dose of DTP/DTaP.</li> <li><input type="checkbox"/> Seizure within three days after receiving a previous dose of DTP/DTaP</li> <li><input type="checkbox"/> Persistent uncontrollable crying lasting 3 hours or more, within 48hrs after receiving a previous dose of DTP/DTaP</li> </ul>
<input type="checkbox"/> <b>Measles, Mumps, Rubella (MMR)</b>	<p><b>Contraindications:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.</li> <li><input type="checkbox"/> Known severe immunodeficiency (e.g, congenital immunodeficiency, malignancy, chemotherapy, long-term immunosuppressive therapy), or human deficiency virus (HIV) infection with CD4+T-lymphocyte ≤ 15%</li> <li><input type="checkbox"/> Pregnancy</li> </ul> <p><b>Precautions:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Moderate to severe acute illness with or without fever.</li> <li><input type="checkbox"/> Recent (within 11mo) receipt of anti-body containing blood product (specific interval depends on product).</li> <li><input type="checkbox"/> History of thrombocytopenia or thrombocytopenic purpura.</li> <li><input type="checkbox"/> Need for tuberculin (TB) testing (Measles vaccine might suppress tuberculin reactivity temporarily).</li> </ul>
<input type="checkbox"/> <b>Varicella (VAR)</b>	<p><b>Contraindications:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.</li> <li><input type="checkbox"/> Known severe immunodeficiency (e.g, congenital immunodeficiency, malignancy, chemotherapy, long-term immunosuppressive therapy), or human deficiency virus (HIV) infection with CD4+T-lymphocyte ≤ 15%</li> <li><input type="checkbox"/> Pregnancy</li> </ul> <p><b>Precautions:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Moderate to severe acute illness with or without fever.</li> <li><input type="checkbox"/> Recent (within 11mo) receipt of anti-body containing blood product (specific interval depends on product).</li> <li><input type="checkbox"/> History of thrombocytopenia or thrombocytopenic purpura.</li> <li><input type="checkbox"/> Receipt of specific antivirals (e.g., acyclovir, famciclovir, valacyclovir) 24hrs before vaccination. Avoid use of the antivirals for 14days after vaccination.</li> </ul>

**A licensed medical provider such as, a Physician (MD or DO), Physicians Assistant (PA) or a Nurse Practitioner (NP) must complete and sign this form.**

Date Exemption Ends: \_\_\_\_\_

Providers Name (please print) \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Providers Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**\* Please attach a copy of the most current shot record, and return to the parent, who will forward to the person requesting this form. \***

**You may retain a copy in the child's medical record.**

**For questions, please contact the Registered Nurse assigned to the facility your child attends.**

