



Medical Immunization Exemption Certificate For Child Care Workers

Section 1: Healthcare Facility and Worker Information

Name of Child Care Facility	Street Address	City	Zip Code	Phone
Child Care Worker Name		Date of Birth		
Street Address	City	Zip Code	Phone	

Section 2: For Healthcare Provider Use Only - Provide name, address, vaccine contraindication(s), signature, and date

Name of Healthcare Provider	Street Address	City	Zip Code	Phone
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1. I certify that due to the contraindication(s) checked below the above named individual is exempt from receiving the required vaccine(s).
2. The contraindication(s) marked below is in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines, American Academy of Pediatrics (AAP) guidelines, or vaccine package insert instructions: (Check where applicable)

Influenza
 MMR
 Varicella
 Tdap

Contraindications	Precautions or Temporary Contraindications
<input type="checkbox"/> Serious allergic reaction (e.g., anaphylaxis) after a previous vaccine dose. (General for all vaccines) <input type="checkbox"/> Serious allergic reaction (e.g., anaphylaxis) to a vaccine component. (General for all vaccines) <input type="checkbox"/> Influenza - severe allergic reaction to egg protein (Injectable and LAIV) <input type="checkbox"/> Influenza (LAIV) - Pregnancy, Immunosuppression, certain chronic medical conditions* <input type="checkbox"/> MMR – contraindicated with immunodeficiency, due to any cause, including HIV <input type="checkbox"/> Varicella – contraindicated with substantial suppression of cellular immunity, including severely immunocompromised with HIV. <input type="checkbox"/> Tdap - Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP, DTaP or Tdap.	<input type="checkbox"/> Moderate or severe acute illness with or without fever <input type="checkbox"/> Recent administration of an antibody-containing blood product (MMR, Varicella) <input type="checkbox"/> Pregnancy - (MMR, Varicella) <input type="checkbox"/> Guillain-Barre syndrome history within 6 weeks after a previous dose (tetanus toxoid-containing vaccine, Influenza vaccine). <input type="checkbox"/> LAIV Flu Vaccine – receipt of specific antivirals 48 hours before vaccination (i.e., amantadine, rimantadine, zanamivir or oseltamivir). Avoid use of these antivirals until 14 days after vaccination. <input type="checkbox"/> Tdap - History of arthus-type hypersensitivity reactions after a previous dose of tetanus toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid containing vaccine. <input type="checkbox"/> Tdap - Progressive or unstable neurologic disorders, defer Tdap vaccination until a treatment regimen has been established and the condition has stabilized.

*Vaccine package inserts and CDC recommendations for these vaccines should be consulted for additional information on vaccine-related contraindications and precautions and for more information on vaccine excipients (www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm). Conditions listed as precautions should be reviewed. Benefits of and risks for administering a specific vaccine to a person under these circumstances should be considered. If the risk from the vaccine is believed to outweigh the benefit, the vaccine should not be administered.

 Healthcare Provider Signature _____
 Date

The identifiable information provided by the health care worker to the facility shall not be re-disclosed to any third party without the written authorization of the health care worker, pursuant to the RI Confidentiality Health care Information Act, RI General Laws chapter 5-37.1. Do not send a copy of this form to the Rhode Island Department of Health. Only non-identifying information aggregated by the facility shall be reported to the RI Department of health for statistical purposes.