DELAWARE STATE UNIVERSITY

CAMPUS HEALTH SERVICES

Medical Exemption Form

The Delaware State University Vaccination Medical Exemption Form is the official Delaware State University document to be completed by a currently licensed physician, advanced practice nurse, nurse practitioner, or physician's assistant to exempt a Delaware State University student, faculty, or staff member from immunization requirements. The clinician certifies that due to the individual's health or medical condition, the individual 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 State University who requires proof of specific immunizations.

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.

Drafted from Delaware Health and Social Services, School Vaccination Medical Exemption Form. Vaccine medical contraindications and precautions are determined by the Centers for Disease Control and Prevention and Advisory Committee on Immunization Practices (4/30/21).

Please return original form to:

Delaware State University
Campus Health Services
1200 North DuPont Hwy.
Dover, DE 19901
Phone: 302-857-6393
Fax: 302-336-9896

Please indicate whether the exemption is permanent or temporary.
For temporary exemption, list the date the exemption ends: ___/___/___

Vaccine	Check if Applicable		Contraindications/Precautions
COVID-19	Permanent	Temporary	Contraindications
	☐	☐	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
			Precautions
	☐	☐	• People with a contraindication to mRNA COVID-19 vaccines (including due to a known PEG allergy): Consideration may be given to vaccination with Janssen COVID-19 vaccine. People who have received one mRNA COVID-19 vaccine dose but for whom the second dose is contraindicated should wait at least 28 days after the mRNA vaccine dose to receive Janssen COVID-19 vaccine.
	☐	☐	• People with a contraindication to Janssen COVID-19 vaccine (including due to a known polysorbate allergy): Consideration may be given to mRNA COVID-19 vaccination. Of note, polysorbate allergy is no longer a contraindication to mRNA COVID-19 vaccination, it is a precaution.
Dtap	Permanent	Temporary	Contraindications
	☐	☐	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
	☐	☐	•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 or DTaP
			Precautions
	☐	☐	• Progressive neurologic disorder, including infantile, spasms, uncontrolled epilepsy, progressive encephalopathy: defer DTaP until neurologic status clarified and stabilized
	☐	☐	• 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
Tdap			Contraindications
	☐	☐	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
	☐	☐	• 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
			Precautions
	☐	☐	• Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has 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
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
MenACWY			Contraindications
	☐	☐	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component, including yeast
			Precautions
	☐	☐	• Moderate or severe acute illness with or without fever
	☐	☐	• Preterm birth (MenACWY-CRM)(f)
MenB			Contraindications
	☐	☐	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
			Precautions
	☐	☐	• Pregnancy
	☐	☐	• Latex sensitivity (MenB-4c)
	☐	☐	• 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
	☐	☐	• Family history of altered immunocompetence(i)
	☐	☐	• Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy(i) or patients with HIV infection who are severely immunocompromised)
			Precautions
	☐	☐	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) History of thrombocytopenia or thrombocytopenic purpura. Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing(k)
	☐	☐	• Moderate or severe acute illness with or without fever

Please complete the information on the back of this page

I am aware that in the event that the Division of Public Health (DPH) and/or Delaware State University (DSU) declares an outbreak of a vaccine preventable disease, or if in the estimation of DPH and/or DSU, I have had, or am at risk of having an exposure to a vaccine preventable disease, I shall be temporarily excluded from being on the Delaware State University campus. This may or may not include physically moving off campus, until the risk period ends. I shall be authorized to return to campus once approved by DPH and/or DSU.

Information

Name (print clearly)____ DOB___/___/___

Signature ____Date:_______________

Name of Parent/Guardian____

(Name required if under the age of 18)

Signature of Parent/Guardian____Date:_______________

(Signature required if under the age of 18)

Provider Information

Clinician Name (print clearly)____MD/DO/APRN/AP

License #____

Signature____ Date________________

Address____

Phone #____

DELAWARE STATE UNIVERSITY

The University is in receipt of your request for a medical or religious exemption. Failure to complete this supplemental form will result in your exemption request being denied.

The University will consider all requests and will provide exemptions in accordance with applicable law. Additional information may be needed to evaluate your request.

Initial decisions to grant Medical/Disability exemptions may be subsequently reviewed based upon evolving medical information and CDC guidance, or other information obtained by the University.

GENERAL INFORMATION:

1. Please provide a brief explanation of why you are requesting an exemption.

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RELIGIOUS EXEMPTION:

1. Have you been vaccinated as an adult (18 yrs. or older)? If so, please identify the vaccines you have received.

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2. Please provide a personal statement regarding why the COVID-19 vaccination is against your religious beliefs. Your statement should also state whether other immunizations are also against your religious beliefs.

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3. Please provide supporting documentation of your belief from a religious body. If you cannot provide supporting documentation, explain why.

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MEDICAL/DISABILITY EXEMPTION:

1. Please provide a statement by your health care provider explaining the medical condition or disability and why an exemption from or delay in vaccination is necessary or appropriate based on CDC's guidance.

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to denial of my request.

Name: ______________________________ Signature: ______________________________

D#: ______________________________ Date: ______________________________