Essentia Health

Vaccine Medical Exemption Form
Request for Medical Exemption from Influenza Vaccination

PLEASE PRINT THE FOLLOWING INFORMATION:

Name: _____ Date of Birth: _____ Phone No: _____
E-mail Address: _____ ~~Department~~ School: _____

Dear Provider,
Essentia Health requires influenza vaccination for all Healthcare Workers. The above-named person is requesting an exemption from this vaccination requirement. A medical exemption from influenza vaccination is allowed for certain recognized contraindications (CDC MMWR Early Release 2011; Vol. 60. Available online: https://www.cdc.gov/mmwr/pdf/wk/mm60e0818.pdf)).

The following are not considered contraindications to influenza vaccination:

- Minor acute illness (e.g., diarrhea and minor upper respiratory tract illnesses, including otitis media)
- Mild to moderate local reactions and/or low- grade moderate fever following a prior dose of the vaccine
- Sensitivity to a vaccine component (e.g. upset stomach, soreness, redness, itching, swelling at the injection site)
- Current antimicrobial therapy (taking prescription anti-influenza therapy is only a temporary contraindication for the live attenuated influenza vaccine [LAI])
- Disease exposure or convalescence
- Pregnant or breast feeding (it is recommended to receive the flu vaccination while pregnant/breast feeding)
- Pregnant or immunosuppressed person in the household
- Since egg free flu vaccine is available, history of egg allergy will not be accepted as a routine medical exemption. As with other injectable flu vaccine types, the egg free option is an FDA approved, safe and effective inactivated vaccine. The egg free does not use any form of eggs in its production and is approved for persons 18 years of age or older.

Please complete the form below:

The above-named individual should not be immunized for influenza for the following reasons. (Please check all that apply.)

☐ Individual has a history of previous allergic reaction and/or documented allergy testing to include an immediate hypersensitivity reaction to the influenza vaccine or a component of the vaccine (***does not include sore arm, local reaction, subsequent upper respiratory tract infection, or egg allergy***)

Please check all allergic reactions that apply:

- ☐ Hives within 24 hours of receiving the influenza vaccine
- ☐ Swelling of the lips, throat, or tongue within a few hours of the influenza vaccine
- ☐ Difficulty breathing within a few hours of the influenza vaccine
- ☐ Other (attach supporting DOCUMENTATION or MEDICAL RECORDS and a narrative of the allergic reaction.)

☐ Individual has a history of Guillain-Barre Syndrome. Family history of Guillain-Barre Syndrome is not a risk factor

☐ Other – Please complete page 2 and provide detailed information as requested to ensure an individualized and timely review of the request (these requests will be reviewed on a case-by-case basis).

I certify that _____ as the above contraindication and request a medical exemption from influenza vaccination.

Provider Signature: _____ Date: _____

Provider Name: _____ Provider Phone No: _____

PLEASE MAIL OR EMAIL COMPLETED FORM TO:
Essentia Health Exemption Review Committee
407 East Third St., DTV – Human Resources
Duluth, MN 55805

OR

Email: FluVaccination@essentiahealth.org

For Essentia Health use only

_____ Approved (Initial) _____ Denied (Initial) _____ Date: _____

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To be completed by provider (or employee if provider not seen) if reason selected is "other".

Please provide detailed information as requested to ensure an individualized and timely review of the request (these requests will be reviewed on a case-by-case basis).

1. Please describe the circumstances and timeline of your adverse health reaction to the influenza vaccine. Indicate if you were treated by a provider, symptoms, and timing /duration of symptoms after vaccination. You may attach a separate narrative if needed.

2. Do you have medical documentation of an adverse health reaction to the influenza vaccine? If yes, please attach medical documentation to your exemption request.

   - ☐ Yes
   - ☐ No

I certify the above contraindication and request a medical exemption from influenza vaccination.

Provider Name:	Employee Name:
Provider Signature:	Employee Signature:
Date:	Date:
Provider Phone No:	