



VACCINE MEDICAL EXEMPTION

State Form 54648 (4-11)

Indiana State Department of Health, Immunization Division

INSTRUCTIONS: 1. This form for any child in grades K – 12 who is unable to receive a vaccine required for school entry due to a medical contraindication.
2. Complete and sign form. Submitted to school as proof of exemption from required immunization.

Patient Name _____ Date of Birth (month/day/year) _____

Parent/Guardian Name _____ Relationship _____

Street Address _____

City _____ ZIP Code _____ Telephone Number _____

General Contraindications to All Vaccines (Vaccine should **not** be given.)

Severe allergic reaction (e.g., anaphylaxis) after a previous vaccine dose or to a vaccine component

- | | | |
|--|--|--|
| <input type="checkbox"/> Hepatitis B (Hep B) | <input type="checkbox"/> Inactivated poliovirus (IPV) | <input type="checkbox"/> Meningococcal, conjugate (MCV4) |
| <input type="checkbox"/> Diphtheria, tetanus, pertussis (DTaP, Tdap) | <input type="checkbox"/> Measles, mumps, rubella (MMR) | or Meningococcal, polysaccharide (MPSV4) |
| <input type="checkbox"/> Tetanus, diphtheria (DT, Td) | <input type="checkbox"/> Varicella (Var) | |

Which vaccine or vaccine component caused reaction? _____

Type of Clinical Reaction & Date (month, day year) _____

Vaccine Specific Contraindications (Vaccine should **not** be given.)

DTaP or Tdap	<input type="checkbox"/> Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within seven (7) days of administration of previous dose of DTP or DTaP
MMR	<input type="checkbox"/> Pregnancy Estimated Date of Confinement (EDC): _____ (month, day year) <input type="checkbox"/> Known severe immunodeficiency (e.g., hematologic and solid tumors; receiving chemotherapy; congenital immunodeficiency; long term immunosuppressive therapy; or patients with HIV infection who are severely immunocompromised)
Varicella	<input type="checkbox"/> Pregnancy Estimated Date of Confinement (EDC): _____ (month, day year) <input type="checkbox"/> Substantial suppression of cellular immunity

Vaccine Specific Precautions (Vaccine may be given or held depending on clinical situation.)

DTaP or Tdap	<input type="checkbox"/> Guillan-Barre syndrome (GBS) within six (6) weeks after a previous dose of tetanus-containing vaccine <input type="checkbox"/> History of Arthus-type hypersensitivity reaction following a previous dose of tetanus and/or diphtheria toxoid-containing vaccine: defer vaccination until at least ten (10) years have elapsed since the previous dose <input type="checkbox"/> Progressive or unstable neurologic disorder, uncontrolled seizures or progressive encephalopathy: defer vaccination with DTaP or Tdap until a treatment regimen has been established and the condition has stabilized
DTaP	<input type="checkbox"/> Temperature of $\geq 105^{\circ}\text{F}$ ($\geq 40.5^{\circ}\text{C}$) within forty-eight (48) hours after vaccination with a previous dose of DTP/DTaP <input type="checkbox"/> Collapse and shock-like state (i.e.: hypotonic hyporesponsive episode) within forty-eight (48) hours after previous dose of DTP/DTaP <input type="checkbox"/> Seizure or convulsion within three (3) days after receiving a previous dose of DTP/DTaP <input type="checkbox"/> Persistent, inconsolable crying lasting three (3) or more hours within forty-eight (48) hours after a previous dose of DTP/DTaP
MMR	<input type="checkbox"/> Recent (within eleven (11) months) receipt of antibody-containing blood product (interval depends on product) <input type="checkbox"/> History of thrombocytopenia or thrombocytopenic purpura
Varicella	<input type="checkbox"/> Recent (within eleven (11) months) receipt of antibody-containing blood product (interval depends on product) <input type="checkbox"/> Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) twenty-four (24) hours before vaccination; if possible, delay resumption of these antiviral drugs for fourteen (14) days after vaccination

Other Medical Contraindication (Must list vaccine(s) and contraindications individually – continue on back if necessary.)

Vaccine	Specific Contraindication

Please indicate the duration of the medical exemption, and if and when vaccine can be safely administered.

(Exemption can last for a maximum of one (1) year, and a new form must be completed annually if medical exemption still applies.)

- ☐ Medical exemption is permanent, and will apply for one (1) year from today's date.
☐ Medical exemption is temporary (<1 year), and resolution is anticipated by ____/____/____
☐ Medical exemption is pregnancy, and Estimated Date of Confinement (EDC) is ____/____/____

Physician Name _____ Physician License Number _____

Office Address _____ Telephone _____

Physician Signature _____ Date (month, day year) _____

**FLAT ROCK HAWCREEK SCHOOL CORPORATION
HAUSER JR. SR. HIGH SCHOOL
HOPE ELEMENTARY SCHOOL**

PARENT/GUARDIAN ACKNOWLEDGMENT FORM FOR STUDENTS WITH VACCINE EXEMPTIONS

Dear Parent/Guardian:

Our records indicate your child has a medical exemption or religious objection to vaccination and is not fully immunized. Although your child remains at risk for contracting vaccine-preventable disease, as you have submitted the appropriate paperwork, Indiana Code 20-34-4 permits your child to attend school.

However, in the event of an outbreak of a vaccine-preventable disease for which your child is not fully vaccinated, your child may be excluded from school to protect his/her health and the health of all students and staff. This includes measles, chickenpox, pertussis, mumps, or any other vaccine-preventable disease at the discretion of the Bartholomew County Health Department.

If your child is excluded from school, your child will also be excluded from after-school activities, such as sporting events, dances, and graduation that occur within the exclusion period. The school nurse will notify you when your child can return to school.

The length of time will vary based on the disease but your child could be excluded for multiple weeks.

Acknowledgement Regarding Incomplete Vaccination

I understand that my child may be excluded from school in the event of an outbreak of a vaccine-preventable disease.

I understand that school exclusion includes after-school activities, such as sporting events, dances, and graduation.

I understand that my child may be required to stay home for multiple weeks during an outbreak of a vaccine-preventable disease for which he/she is not fully vaccinated.

Student's Name: _____ Student's Grade: _____

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____

Date: _____