Connecticut Department of Public Health
Medical Exemption Certification Statement

According to State statutes (Connecticut General Statutes Sections 19a-7f and 10-204a), no child may be admitted to a licensed child care program or school without proof of immunization or a statement of exemption. Parents or guardians claiming a medical exemption on the basis that a given immunization is medically contraindicated should complete the following statement and attach a letter signed by a physician licensed to practice medicine stating that in the physician's opinion, such immunization is medically contraindicated and return it to the school or child care facility. The letter must include the child's name, birth date, the vaccine(s) for which exemption is being filed and the condition that contraindicates vaccination, as well as the physician's signature and contact information.

To Whom It May Concern:

As the parent(s)/guardian(s) of _____,
(Name of student)

I/we are submitting the enclosed documentation from a physician that immunization of this child is medically contraindicated. Therefore, this child is exempt from receiving the required immunization as specified by the physician, and shall be permitted to attend a licensed child care program or school except in the case of a vaccine-preventable disease outbreak.

_____/_____
Signature of Parent(s)/Guardian(s) Date

_____/_____
Signature of Parent(s)/Guardian(s) Date

_____
Address

_____
Telephone #

Children with medical exemptions shall be permitted to attend a licensed child care program or school except in the case of an outbreak of vaccine-preventable disease. In the event of an outbreak of vaccine preventable disease, all susceptible children will be excluded from child care or school settings based on public health officials' determination that the child care facility or school is a significant site for disease exposure, transmission and spread into the community. Children without proof of immunity, including children with religious and medical exemptions shall be excluded from these settings for this reason and will not be able to return until (1) the danger of the outbreak has passed as determined by public health officials, (2) the child becomes ill with the disease and completely recovers, or (3) the child is immunized.

Student Medical **Exemption Certificate for Required Immunizations**

Name of Primary Care Provider granting exemption: _____

Please check one (practitioner granting exemption must be licensed as one of the following):

☐ Physician (MD or DO) ☐ Physician Assistant ☐ APRN

CT License number: _____

NPI: _____

Phone number: _____ Email: _____

Directions:

Part 1. Please complete the demographics section on the patient/student.

Part 2. Please mark the contraindications/precautions that apply to this patient/student (indicate all that apply).

Part 3. If no contraindications or precautions apply in part 2, write a brief explanation of the reason the patient/student requires the exemption.

Part 4. Sign the Statement of Clinical Opinion and date the form.

Attach a copy of the patient/student's most current immunization record.

Part 1. Patient/Student Information:

First name (in full) _____ Middle initial _____ Last name _____

Date of Birth _____

Mailing Address _____ City _____

State _____ Zip _____

Parent/Guardian: First Name _____ Last name _____

Primary phone number _____

School name _____

School address

_____

City _____

State _____ Zip _____

Current or Grade student is entering _____

Part 2. Please mark the vaccine(s), exemption duration, and all contraindications/precautions that apply to this patient/student for each vaccine.

Medical contraindications and precautions for immunizations are based upon the Advisory Committee on Immunization Practices (ACIP) Comprehensive General Recommendations and Guidelines, published by the Centers for Disease Control and Prevention.

A **contraindication** is a condition in a recipient that increases the risk for a serious vaccine adverse event (VAE) or compromises the ability of the vaccine to produce immunity.

A **precaution** is a condition in a recipient that might increase the risk for a serious VAE or that might compromise the ability of the vaccine to produce immunity. Under normal conditions, vaccinations are deferred when a precaution is self-limiting, but can be administered if the precaution condition improves.

CDC Recognized Contraindications and Precautions

Vaccine	Exemption Duration	**ACIP Contraindications and Precautions (Check all that apply)**
☐ **Diphtheria-Tetanus-and acellular Pertussis (DTaP)**	☐ Temporary through: ____/_____ mm/ yyyy ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Encephalopathy within seven days after receipt 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 ☐ GBS <6 weeks after previous dose of tetanus-toxoid–containing vaccine ☐ Fever greater than 40.5°C (104.9°F) <48 hours after vaccination of previous dose of DTP or DTaP ☐ History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid–containing or tetanus-toxoid–containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid–containing vaccine ☐ Moderate or acute illness with or without fever
☐ **Hepatitis A**	☐ Temporary through: ____/_____ mm/ yyyy ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component **Precautions** ☐ Moderate or severe acute illness with or without fever

☐ **Hepatitis B**	☐ Temporary through: ____/_____ mm/ yyyy ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Hypersensitivity to yeast **Precautions** ☐ Moderate or severe acute illness with or without fever
☐***Haemophilus influenza*e type b (HiB)**	☐ Temporary through: ____/_____ mm/ yyyy ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Age <6 weeks **Precautions** ☐ Moderate or severe acute illness with or without fever
☐ **Inactivated Influenza Virus (IIV)**	☐ Temporary through: ____/_____ mm/ yyyy ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after previous dose of influenza vaccine or to vaccine component **Precautions** ☐ GBS <6 weeks after a previous dose of influenza vaccine ☐ Moderate or severe acute illness with or without fever ☐ Egg allergy other than hives, e.g., angioedema, respiratory distress, lightheadedness, recurrent emesis; or required epinephrine or another emergency medical intervention (IIV may be administered in an inpatient or outpatient medical setting and under the supervision of a health care provider who is able to recognize and manage severe allergic conditions).
☐ **Inactivated Polio Vaccine (IPV)**	☐ Temporary through: ____/_____ mm/ yyyy ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component **Precautions** ☐ Pregnancy ☐ Moderate or acute illness with or without fever

☐ **Live Attenuated Influenza Virus (LAIV)**	☐ Temporary through: ____/____ mm/ yyyy ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Concomitant use of aspirin or aspirin-containing medication in children and adolescents ☐ LAIV4 should not be administered to persons who have taken oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days.(e) ☐ Pregnancy ☐ Children aged 2 through 4 years who have received a diagnosis of asthma or whose parents or caregivers report that a health care provider has told them during the preceding 12 months that their child had wheezing or asthma or whose medical record indicates a wheezing episode has occurred during the preceding 12 months. ☐ Persons with active cerebrospinal fluid/oropharyngeal communications/leaks. ☐ Close contacts and caregivers of severely immunosuppressed persons who require a protected environment. ☐ Persons with cochlear implants (due to the potential for CSF leak, which might exist for some period of time after implantation. Providers might consider consultation with a specialist concerning risk of persistent CSF leak if an age-appropriate inactivated or recombinant vaccine cannot be used). ☐ Altered Immunocompetence ☐ Anatomic or functional asplenia (e.g. sickle cell disease) **Precautions** ☐ GBS <6 weeks after a previous dose of influenza vaccine ☐ Asthma in persons aged 5 years old or older ☐ Medical conditions which might predispose to higher risk of complications attributable to influenza(d) ☐ Moderate or severe acute illness with or without fever
☐ **Meningo-coccal conjugate vaccines (MenACWY)**	☐ Temporary through: ____/____ mm/ yyyy ☐ Permanent	**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

☐ **Measles-Mumps-Rubella (MMR)**	☐ Temporary through: ____/____ mm/ yyyy ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Pregnancy ☐ 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) ☐ Family history of altered immunocompetence (i) **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
☐ **Pneumo-coccal (PCV13)**	☐ Temporary through: ____/____ mm/ yyyy ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose of PCV13 or any diphtheria-toxoid–containing vaccine or to a component of a vaccine (PCV13 or any diphtheria-toxoid–containing vaccine), including yeast **Precautions** ☐ Moderate or acute illness with or without fever
☐ **Tdap**	☐ Temporary through: ____/____ mm/ yyyy ☐ Permanent	**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** ☐ GBS <6 weeks after a previous dose of tetanus-toxoid–containing vaccine ☐ Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized ☐ History of Arthus-type hypersensitivity reactions after a previous

		dose of diphtheria-toxoid—containing or tetanus-toxoid–containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid–containing vaccine ☐ Moderate or severe acute illness with or without fever
☐ **Varicella**	☐ Temporary through: ____/_____ mm/ yyyy ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ 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) (g) ☐ Pregnancy ☐ Family history of altered immunocompetence (j) **Precautions** ☐ Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) ☐ Moderate or acute illness with or without fever

Part 3. Other Allergic Reactions/ Other Type of Medical Condition

Complete this section if claiming a medical exemption for a vaccine based on a condition that does meet any of the ACIP criteria for a contraindication or precaution listed in part 2.

Vaccine(s), list all that apply: _____

_____

For each vaccine listed above, select the allergic or other reaction for which medical exemption is being submitted. Please check off any of the following that apply:

☐ This patient has an autoimmune disorder

☐ This patient has a family history of an autoimmune disorder

☐ This patient has a family history of a reaction to a vaccination

☐ This patient has a genetic predisposition to a reaction to a vaccination as determined through genetic testing

☐ This patient has a previous documented reaction that is correlated to a vaccination

☐ Other condition/reaction not listed above (must specify): _____

Please provide an explanation of the reaction/condition listed above:

_____

Part 4. Statement of Clinical Opinion

In accord with the legal requirements of Public Act 21-6, the vaccine(s) indicated above is/are in my clinical opinion medically contraindicated for this patient/student due to the physical condition as explained above.

Clinician's Signature _____

Date _____

A person may be placed into quarantine or isolation when there are "reasonable grounds to believe to be infected with, or exposed to, a communicable disease or to be contaminated or exposed to contamination or at reasonable risk of having a communicable disease or being contaminated or passing such communicable disease or contamination to other persons if the commissioner determines that such individual or individuals pose a significant threat to the public health and that quarantine or isolation is necessary and the least restrictive alternative to protect or preserve the public health." Conn. Gen. Stat. § 19a-131b(a).