Medical Exemption Form

Instructions for completing Medical Exemption Form:
Section 1: Completed by parent/guardian or student (aged ≥18 years): Enter child care facility, school, or post-secondary school, and student information
Section 2: Completed by licensed health care provider (MD, DO, ND, APRN-Rx, PA): Check exempted vaccine, contraindication or precaution, or both, and complete duration of exemption

Section 1: Child Care Facility, School, Post-Secondary School, and Student Information

Student's Name:	Student's Date of Birth:		
Student's Home Address	City	State	Zip
Name of Child Care Facility, School, Post-Secondary School	Street Address	City	Zip

I understand that if at any time there is, in the opinion of the Department of Health, danger of an outbreak or epidemic from any communicable disease for which immunization is required, this exemption from immunization shall not be recognized and the student named above will be excluded from attending the child care facility, school, or post-secondary school until the Director of Health has determined that the presence of the outbreak no longer exists [HRS §302A-1157].

Parent/Guardian Name [if student <18 years]. (Please print): _____

Parent/Guardian **OR** Student (if aged ≥18 years) Signature: _____ Date: _____

Section 2: For Health Care Provider Use ONLY (MD, DO, ND, APRN-Rx, PA):

VACCINE	**CONTRAINDICATIONS*** (Check all that apply to this patient):	**PRECAUTIONS*** (Check all that apply to this patient)	**FROM:**	**TO:**
☐ **DTaP** ☐ **Tdap** ☐ **DT, Td**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ **DTaP/Tdap only**: 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, Tdap	☐ Guillain-Barre Syndrome <6 weeks after previous dose of tetanus-toxoid-containing vaccine ☐ History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid-containing or tetanus-toxoid-containing vaccine ☐ Moderate or severe acute illness with or without fever ☐ **DTaP/Tdap only:** Progressive or unstable neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy	/ /	/ /
☐ **Hib**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Age <6 weeks	☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ **Hep A**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ **Hep B**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Hypersensitivity to yeast	☐ Moderate or severe acute illness with or without fever	/ /	/ /

*https://health.hawaii.gov/docd/files/2019/08/HAR11-157_EXHIBIT_B.pdf

Student's Name: _____ **Student's Date of Birth:** _____

Section 2: For Health Care Provider Use ONLY (MD, DO, ND, APRN-Rx, PA):				
VACCINE	**CONTRAINDICATIONS*** (Check all that apply to this Patient):	**PRECAUTIONS*** (Check all that apply to this patient)	**FROM:**	**TO:**
☐ **HPV**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	☐ Pregnancy ☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ **MMR**	☐ 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 or patients with HIV infection who are severely immunocompromised) ☐ Family history of altered immunocompetence	☐ Recent (<11 months) receipt of antibody-containing blood product ☐ History of thrombocytopenia or thrombocytopenic purpura ☐ Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing ☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ **MCV**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ **PCV**	☐ 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)	☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ **IPV**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	☐ Pregnancy ☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ **Varicella**	☐ 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 or patients with HIV infection who are severely immunocompromised) ☐ Pregnancy ☐ Family history of altered immunocompetence	☐ Recent (<11 months) receipt of antibody-containing blood product ☐ Moderate or severe acute illness with or without fever ☐ Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination ☐ Use of aspirin or aspirin-containing products	/ /	/ /

I certify that in my medical judgement, due to the contraindication(s)/precaution(s) noted above, this student is exempt from the specific vaccine(s) named for the period indicated.

Health care provider's name/Title (Please Print): _____ License number: _____

Address: _____

Health care provider's signature: _____ Date: _____

Give completed original form to parent/guardian or student (aged ≥18 years). Send COPY of form to: State of Hawaii Department of Health, Immunization Branch, P.O. Box 3378, Honolulu, HI 96801 OR Fax to (808) 586-8347.

DTaP=Diphtheria, Tetanus, acellular Pertussis, Tdap=Tetanus, diphtheria, acellular pertussis, DT=diphtheria, tetanus, Td=tetanus, diphtheria, Hib=*Haemophilus influenzae* type B, Hep A=hepatitis A, Hep B=hepatitis B, HPV=human papillomavirus, MMR=measles, mumps, rubella, MCV=meningococcal conjugate vaccine, PCV=pneumococcal conjugate vaccine, IPV=inactivated poliovirus vaccine

State of Hawaii Department of Health
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