Medical Immunization Exemption Certificate
For Use in Public and Private Daycare, Preschool, School & College

Instructions for completing a Medical Immunization Exemption Certificate (Press down firmly to mark all copies)
Section 1: Enter school and student information.
Section 2: For health care provider use only. Please provide name, address, vaccine contraindication(s), signature and date.
Section 3: For school use only: Obtain school signatures and dates and distribute copies as outlined below.

Section 1: School and Student Information

Name of Daycare, School, or Institution	Street Address	City	Zip Code	Phone

Student Name	Date of Birth	Grade/Level

Street Address	City	Zip Code	Phone

Section 2: For Healthcare Provider Use Only - Provide name, address, vaccine contraindication(s), signature, and date.

Name of Healthcare Provider	Street Address	City	Zip Code	Phone

1. I certify that due to a contraindication(s) the above named student is exempt from receiving the required vaccine(s):
2. The contraindication(s) marked below is in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines, American Academy of Pediatrics (AAP) guidelines, or vaccine package insert instructions: (Check where applicable)

☐ DTaP ☐ Hepatitis A ☐ Hepatitis B ☐ HIB ☐ HPV ☐ Influenza ☐ IPV ☐ MCV ☐ MMR
☐ PCV ☐ Td/Tdap ☐ Rotavirus ☐ Varicella

Contraindications	Precautions or Temporary Contraindications
☐ Serious allergic reaction (e.g., anaphylaxis) after a previous vaccine dose. (General for all vaccines) ☐ Serious allergic reaction (e.g., anaphylaxis) to a vaccine component. (General for all vaccines) ☐ Previous encephalopathy not attributable to another identifiable cause within 7 days of administration of previous dose of DTaP/DTP. ☐ Progressive neurological problem after DTaP/DTP ☐ MMR contraindicated with immunodeficiency, due to any cause, including HIV ☐ Varicella contraindicated with substantial suppression of cellular immunity ☐ Rotavirus contraindicated with severe combined immunodeficiency (SCID).	☐ Recent administration of an antibody-containing blood product (MMR, Varicella) ☐ Student is pregnant. (MMR, Varicella, HPV) ☐Thrombocytopenia/thrombocytopenic purpura- now or by history (MMR) ☐ Rotavirus – altered immunocompetence other than SCID, history of iIntussusception, chronic GI disease, spina bifida or bladder exstrophy Any of the conditions below after a previous dose of DTP or DTaP: ☐ Neurologic disorder – unstable or evolving ☐ Fever of ≥105° F (40.5° C) unexplained by another cause (within 48 hours) ☐ Seizure or convulsion within 72 hours ☐ Persistent, inconsolable crying lasting ≥ 3 (within 48 hours) ☐ Collapse or shock like state (within 48 hours) ☐ Guillain-Barré Syndrome (within 6 weeks) ☐ History of arthus-type hypersensitivity, defer Tetanus-toxoid vaccine for at least 10 years since last dose.

Parent/student has been informed that if an outbreak of vaccine -preventable disease should occur, an exempt student will be excluded from school by the school administrative head for a period of time as determined by the Health Department based on a case-by-case analysis of public health risk.

_____ Healthcare Provider Signature

_____ Date

Section 3: For School Official Use Only: Please provide date and signatures and distribute copies as outlined below.

_____ School Nurse Signature

_____ Date

_____ School Administrative Head Signature

_____ Date

Note: In accordance with the Rhode Island Department of Health's Rules and Regulations Pertaining to Immunization and Testing for Communicable Diseases (216-RICR-30-05-3), it is the responsibility of the administrative head of the daycare, preschool, school, or college to secure compliance with the regulations. The administrative head of the daycare, preschool, school, or college shall exclude students who have not received the minimum number of required immunizations and who are not exempt pursuant to the regulations.