



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

- Hepatitis B (Hep B)  Inactivated poliovirus (IPV)  Meningococcal, conjugate (MCV4)  
 Diphtheria, tetanus, pertussis (DTaP, Tdap)  Measles, mumps, rubella (MMR) or Meningococcal, polysaccharide (MPSV4)  
 Tetanus, diphtheria (DT, Td)  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 regiment 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 dwgs 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): \_\_\_\_\_