EMPLOYEE or PROVIDER REQUEST ONLY

INFLUENZA VACCINATION MEDICAL EXEMPTION REQUEST FORM

Please Print

Name: _____ Date of Birth: _____/_____/_____

Employee No: _____ Job Title: _____ Phone: _____

Email:_____

Department: _____ Supervisor/Manager: _____

Licensed Independent Practitioner Name: _____

Licensed Independent Practitioner Phone No.: _____

Southeast Health requires influenza vaccination. The above-named person is requesting an exception from this vaccination requirement. A medical exemption from influenza vaccination is allowed for certain recognized contraindications as noted by the CDC and ACIP.

The physician should complete the rest of this section of the form and sign at the bottom.

Should you have any questions, please contact Southeast Health Employee Health at 334-793-8005.

The above person should not receive an influenza vaccination for the following reasons: *(initial all that apply)*

initials	
	History of previous allergic reaction and documented allergy testing to indicate an immediate hypersensitivity reaction to the influenza vaccine or a component of the vaccine. **Supporting DOCUMENTATION or MEDICAL RECORDS must be attached.**
	History of Guillain-Barre Syndrome within six weeks of receiving a previous vaccine. **Supporting DOCUMENTATION or MEDICAL RECORDS must be attached.**
	Other - **Supporting DOCUMENTATION or MEDICAL RECORDS must be attached.**

Please initial one of the following statements:

_____ I certify that this individual has the above contraindication(s) and request a medical exemption from influenza vaccination.

_____ I DO NOT certify that this individual has known contraindication(s).

Physician Signature: _____ **Date**: _____

(Note: Signature stamp NOT acceptable)

DESIGNATED OFFICE USE ONLY:

Medical Exception Approved on: ____ / ____ / ____ Approving Staff Signature: _____

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(The employee should complete this section of the form and sign at the bottom)

Explain in your own words why you are requesting this exemption.

I hereby affirm the truthfulness of this statement.

Sign Here: _____ _____

Signature *Date*

Fax or E-mail this form to Southeast Health Employee Health:

Fax: (334) 673-4153

E-mail: EmployeeHealthStaff@southeasthealth.org