



## 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:
<input type="checkbox"/> <b>DTaP</b> <input type="checkbox"/> <b>Tdap</b> <input type="checkbox"/> <b>DT, Td</b>	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> <b>DTaP/Tdap only:</b> 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	<input type="checkbox"/> Guillain-Barre Syndrome <6 weeks after previous dose of tetanus-toxoid-containing vaccine <input type="checkbox"/> History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid-containing or tetanus-toxoid-containing vaccine <input type="checkbox"/> Moderate or severe acute illness with or without fever <input type="checkbox"/> <b>DTaP/Tdap only:</b> Progressive or unstable neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy	/ /	/ /
<input type="checkbox"/> <b>Hib</b>	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Age <6 weeks	<input type="checkbox"/> Moderate or severe acute illness with or without fever	/ /	/ /
<input type="checkbox"/> <b>Hep A</b>	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	<input type="checkbox"/> Moderate or severe acute illness with or without fever	/ /	/ /
<input type="checkbox"/> <b>Hep B</b>	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Hypersensitivity to yeast	<input type="checkbox"/> Moderate or severe acute illness with or without fever	/ /	/ /

\*[https://health.hawaii.gov/docd/files/2019/08/HAR11-157\\_EXHIBIT\\_B.pdf](https://health.hawaii.gov/docd/files/2019/08/HAR11-157_EXHIBIT_B.pdf)

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:
<input type="checkbox"/> HPV	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Moderate or severe acute illness with or without fever	/ /	/ /
<input type="checkbox"/> MMR	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Pregnancy <input type="checkbox"/> 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) <input type="checkbox"/> Family history of altered immunocompetence	<input type="checkbox"/> Recent (<11 months) receipt of antibody-containing blood product <input type="checkbox"/> History of thrombocytopenia or thrombocytopenic purpura <input type="checkbox"/> Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing <input type="checkbox"/> Moderate or severe acute illness with or without fever	/ /	/ /
<input type="checkbox"/> MCV	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	<input type="checkbox"/> Moderate or severe acute illness with or without fever	/ /	/ /
<input type="checkbox"/> PCV	<input type="checkbox"/> 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)	<input type="checkbox"/> Moderate or severe acute illness with or without fever	/ /	/ /
<input type="checkbox"/> IPV	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Moderate or severe acute illness with or without fever	/ /	/ /
<input type="checkbox"/> Varicella	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> 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) <input type="checkbox"/> Pregnancy <input type="checkbox"/> Family history of altered immunocompetence	<input type="checkbox"/> Recent (<11 months) receipt of antibody-containing blood product <input type="checkbox"/> Moderate or severe acute illness with or without fever <input type="checkbox"/> Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination <input type="checkbox"/> 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