**North Carolina Department of Health and Human Services**
**Division of Public Health**

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**MEMORANDUM**

**TO:** North Carolina Immunization Program (NCIP) Participants

**FROM:** Wendy Holmes, R.N., Head WH
Immunization Branch

**DATE:** June 17, 2015

**SUBJECT:** Revised Medical Exemption Statement and Physician's Request Forms

The purpose of this memo is to notify NCIP providers of important revisions to the Medical Exemption Statement Form (DHHS-3987), and Physician's Request for Medical Exemption Form (DHHS-3995). Providers should begin using the revised forms effective July 1, 2015. Please dispose of or recycle any previous editions of these forms that you have and discontinue use after July 1, 2015.

The revised forms are attached for your convenience and use. Additional copies can be downloaded from the Immunization Branch web site at www.immunize.nc.gov.

Providers who have questions about the forms should contact the Immunization Branch Nurse on-Call Line at 919-707-5575.

Thank you for all you do to protect the health of North Carolinians.

Attachments

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North Carolina Department of Health and Human Services
Women's and Children's Health Section ▪ Immunization Branch

# MEDICAL EXEMPTION STATEMENT

Purpose: To provide physicians, licensed to practice medicine in North Carolina, a mechanism to document a true medical contraindication/precaution to an immunization(s). This form does not need approval from the State Health Director. This form can be accepted by agencies that require proof of immunizations. For medical exemptions NOT listed in the table below, submit the Physician's Request for Medical Exemption form (Form: DHHS 3995) to the State Health Director for approval, available at http://www.immunize.nc.gov/schools/ncexemptions.htm

Name of Patient _____DOB _____

Name of Parent/Guardian _____ Primary Phone (  ) _____

Home Address (Patient/Parent) _____County_____

Name of Child Care/School/College/University _____

Medical contraindications and precautions for immunizations are described in the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP), available at http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm

A **contraindication** is a condition in a recipient that increases the risk for a serious adverse reaction. A vaccine will not be administered when a contraindication is present. A **precaution** is a condition in a recipient that might increase the risk for a serious adverse reaction or that might compromise the ability of the vaccine to produce immunity. Under normal conditions, vaccinations should be deferred when a precaution is present.

| Vaccine | Check all true contraindications and precautions that apply to this patient below: |
|---|---|
| ☐ **Diphtheria, tetanus, pertussis (DTaP)**<br><br>☐ **Tetanus, diphtheria, pertussis (Tdap)**<br><br>☐ **Tetanus, diphtheria (DT, Td)** | **Contraindications**<br>☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.<br>☐ For pertussis-containing vaccines: encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizure) not attributable to another identifiable cause within 7 days of administration of DTaP or DTP (for DTaP); or of previous dose of DTaP, DTP, or Tdap (for Tdap).<br>**Precautions**<br>☐ Moderate or severe acute illness with or without fever.<br>☐ Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus toxoid-containing vaccine.<br>☐ History of arthus-type hypersensitivity reaction after a previous dose of a tetanus or diphtheria toxoid-containing vaccine; defer until at least 10 years have elapsed since the last tetanus-toxoid containing vaccine.<br>☐ For pertussis-containing vaccines: progressive or unstable neurologic disorder (including infantile spasms for DTaP), uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized.<br>**Additional Precautions that only apply to DTaP**<br>☐ Temperature of 105° F or higher (40.5° C or higher) within 48 hours after vaccination with a previous dose of DTP/DTaP.<br>☐ Collapse or shock-like state (i.e., hypotonic hyporesponsive episode) within 48 hours after receiving a previous dose of DTP/DTaP.<br>☐ Seizure within 3 days after receiving a previous dose of DTP/DTaP.<br>☐ Persistent, inconsolable crying lasting 3 or more hours within 48 hours after receiving a previous dose of DTP/DTaP. |
| ☐ **Measles, mumps, rubella (MMR)** | **Contraindications**<br>☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.<br>☐ Known severe immunodeficiency (e.g., congenital immunodeficiency, malignancy, chemotherapy, long-term immunosuppressive therapy, or human immunodeficiency virus [HIV] infection with CD4+ T-lymphocyte count ≤ 15%).<br>☐ Pregnancy.<br>**Precautions**<br>☐ Moderate or severe acute illness with or without fever.<br>☐ Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product).<br>☐ History of thrombocytopenia or thrombocytopenic purpura.<br>☐ Need for tuberculin skin testing (Measles vaccine might suppress tuberculin reactivity temporarily) |

| | |
|---|---|
| ☐ **Varicella (Var)** | **Contraindications**<br>☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.<br>☐ Known severe immunodeficiency (e.g., congenital immunodeficiency, malignancy, chemotherapy, long-term immunosuppressive therapy, or human immunodeficiency virus (HIV) infection with CD4+ T-lymphocyte count ≤ 15%.<br>☐ Pregnancy.<br>**Precautions**<br>☐ Moderate or severe acute illness with or without fever<br>☐ Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product)<br>☐ Receipt of specific antivirals (e.g., acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination. Avoid use of these antivirals for 14 days after vaccination. |
| ☐ **Inactivated Polio Virus (IPV)** | **Contraindications**<br>☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.<br>**Precautions**<br>☐ Moderate or severe acute illness with or without fever.<br>☐ Pregnancy. |
| ☐ **Hepatitis B (Hep B)** | **Contraindications**<br>☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.<br>**Precautions**<br>☐ Moderate or severe acute illness with or without fever.<br>☐ Infant weighing less than 2000 grams (4 lbs, 6.4 oz) if mother is documented hepatitis B surface antigen (HbsAg) negative at the time of the infant's birth. |
| ☐ ***Haemophilus Influenza* type B (HIB)** | **Contraindications**<br>☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.<br>☐ Age younger than 6 weeks.<br>**Precautions**<br>☐ Moderate or severe acute illness with or without fever. |
| ☐ **Pneumococcal (PCV13)** | **Contraindications**<br>☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component, including any diphtheria toxoid-containing vaccine.<br>**Precautions**<br>☐ Moderate or severe acute illness with or without fever. |
| ☐ **Meningococcal (MCV4)** | **Contraindications**<br>☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component<br>**Precautions**<br>☐ Moderate or severe acute illness with or without fever |

**A physician (M.D. or D.O) licensed to practice medicine in North Carolina must complete and sign this form.**

**Date exemption ends:** _____

N.C. Physician's Name (please print) _____ Phone _____

Address _____

N.C. Physician's Signature _____ Date _____

**Instructions:**

1. Complete and sign the form.
2. **Attach a copy of the most current immunization record.**
3. Retain a copy for the patient's medical record.
4. Return the original to the person requesting this form.

For questions call (919) 707-5550

Additional copies of this form can be accessed at: http://www.immunize.nc.gov/schools/ncexemptions.htm

North Carolina Department of Health and Human Services
Women's and Children's Health Section ▪ Immunization Branch

# PHYSICIAN'S REQUEST FOR MEDICAL EXEMPTION

**Purpose:** To provide physicians, licensed to practice medicine in North Carolina, with a mechanism to request a medical exemption from the State Health Director that is not specified in the North Carolina Administrative Code (10 NCAC 41A. 0404) and not listed on the Medical Exemption Statement form (Form: DHHS 3987), available at http://www.immunize.nc.gov/schools/ncexemptions.htm

Name of Patient _____DOB_____

Name of Parent/Guardian _____Primary Phone (  ) _____

Home Address (Patient/Parent) _____County_____

Name of Child Care/School/College/University_____

**G.S. 130A-156. Medical exemption.** The Commission for Health Services shall adopt by rule a list of medical contraindications to immunizations required by G.S. 130A-152. If a physician licensed to practice medicine in this State certifies that a required immunization is or may be detrimental to a person's health due to the presence of one of the contraindications listed by the Commission, the person is not required to receive the specified immunization as long as the contraindication persists. The State Health Director may, upon request by a physician licensed to practice medicine in this State, grant a medical exemption to a required immunization for a contraindication not on the list adopted by the Commission.

**Please mark the vaccine(s) that the proposed medical exemption(s) apply to:**

| | | |
|---|---|---|
| ☐ DTaP | ☐ MMR | ☐ Hepatitis B |
| ☐ Tdap | ☐ Varicella | ☐ Hib |
| ☐ DT/Td | ☐ IPV | ☐ Meningococcal |
| ☐ Pneumococcal Conjugate | ☐ Other (Specify)_____ | |

**For each vaccine marked above, please describe the contraindication(s) and the proposed length of time that would apply: _____**

_____

_____

_____

_____

_____

_____

**A physician (M.D. or D.O.) licensed to practice medicine in NC must complete and sign this form.**

N.C. Physician's Name (please print) _____ Phone _____

Address _____

N.C. Physician's Signature _____ Date _____

**INSTRUCTIONS**

1. Complete and sign the form.
2. Provide documentation to support the request (clinic notes, labs, etc).
3. **Attach a copy of the most current immunization record.**
4. Retain a copy for the patient's file.
5. Provide a copy to the person requesting the medical exemption.
6. Send the completed form, supporting documentation and the current immunization record to:

   State Health Director
   Department of Health and Human Services
   Immunization Branch
   1917 Mail Service Center
   Raleigh, NC 27699-1917

For questions call (919)707-5550.
Additional copies of this form can be accessed at: http://www.immunize.nc.gov/schools/ncexemptions.htm