Association of Camp Nursing

REQUEST FOR MEDICAL EXEMPTION FROM IMMUNIZATION

TEMPLATE

INSTRUCTIONS FOR COMPLETION

1. Fill out the form completely. ALL form fields are required except where noted as being optional.
    a. Enter the name of the Camper and other identifying information.
    b. Please complete all required information in table one as requested.
2. Sign and date the Attestation Statement
3. Provide a completed copy to the camp for review. Keep a copy of the form for your records.

Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP), available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html or https://redbook.solutions.aap.org/redbook.aspx

Please check the website to ensure that you are reviewing the most recent ACIP information.

Please note that the presence of a moderate to severe acute illness with or without fever is a precaution to administration of all vaccines. However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication.

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Name of Camper: *first / middle / last*	Date of Birth:
Name of Parent/Guardian (if under 18): *first / middle / last*	Primary Phone:
Patient/Parent Home Address: *address 1* *address 2* *city* *state* *zip*	
Camper/Parent Email Address:	

Table 1. ACIP Contraindications and Precautions to Vaccination for Mandatory Vaccines

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
☐ **Covid-19 Vaccine**	☐ Temporary through: _____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Known diagnosed allergy to a component of the COVID-19 vaccine **Precautions** ☐ Recent antibody-based therapies (e.g.,monoclonal antibodies or convalescent plasma) should wait a period of time after treatment to be vaccinated against COVID-19. ☐ Any immediate allergic reaction to other vaccines (non-COVID-19) or injectable therapies ☐ Non-severe, immediate (onset <4 hours) allergic reaction after previous dose of COVID-19 vaccine

Attestation

I am a physician (M.D. or D.O) licensed to practice medicine in a jurisdiction of the United States or an advanced practice nurse (N.P./P.A) licensed in a jurisdiction of the United States.

By signing below, I affirm that I have reviewed the current ACIP Contraindications and Precautions and affirm that the stated contraindication(s)/precaution(s) is enumerated by the ACIP and consistent with established national standards for vaccination practices. I understand that I might be required to submit supporting medical documentation. I also understand that any misrepresentation might result in referral to the appropriate licensing/regulatory agency.

Healthcare Provider Name (please print): _____ Specialty: _____

NPI Number: _____ License Number: _____ Stateof Licensure: _____

Phone: _____ Fax: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ Date: _____