Kean Wellness Center Student Health Services
1000 Morris Ave. Union, NJ 07083 | Downs Hall, Room 126
Tel: (908) 737-4880 | Email: studenthealthservices@kean.edu
To submit this form, go to *kean.studenthealthportal.com*

NJDOH MEDICAL EXEMPTION REQUEST

Instructions: This form is to be used to request a medical exemption *ONLY*. Fill out the form completely.

Student's Name: (first, last)	Date of Birth:
Kean ID Number:	Kean Email:

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.

ACIP Contraindications and Precautions to Vaccination for Mandatory Vaccines

1. Check off each vaccine for which an exemption is requested.
2. For each vaccine for which an exemption is requested, check to indicate whether the exemption is Temporary (indicate the date through which the exemption is valid) or Permanent.
3. Check the ACIP contraindication/precaution applicable for each vaccine for which an exemption is requested.

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
❒ MMR (Measles, Mumps, Rubella)	❒ Temporary through: (date) _____ ❒ Permanent	**Contraindications:** ❒ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ❒ Pregnancy ❒ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with human immunodeficiency virus [HIV] infection who are severely immunocompromised) ❒ Family history of congenital or hereditary immunodeficiency in first degree relatives (e.g., parents and siblings), unless the immune competence of the potential vaccine recipient has been substantiated clinically or verified by a laboratory test **Precautions:** ❒ Recent (≤ 11 months) receipt of antibody-containing blood product (specific interval depends on product) ❒ History of thrombocytopenia or thrombocytopenic purpura ❒ Need for tuberculin skin testing or interferon gamma release assay (IGRA) testing

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❒ Hepatitis B (HepB)	❒ Temporary through: (date) ❒ Permanent	**Contraindications:** ❒ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ❒ Hypersensitivity to yeast
❒ Meningococcal (MenACWY)	❒ Temporary through: (date) ❒ Permanent	**Contraindications:** ❒ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
❒ Meningococcal (MenB)	❒ Temporary through: (date) ❒ Permanent	**Contraindications:** ❒ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component **Precautions:** ❒ Pregnancy
❒ Other. Please explain fully and attach additional sheets as necessary. Be sure to check Table 4-2 ACIP Examples of Conditions incorrectly perceived as contraindications or precautions to vaccination (i.e., vaccines may be given under these conditions) https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.		

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 (APN) 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 New Jersey State Board of Medical Examiners and/or appropriate licensing/regulatory agency.

Healthcare Provider Name (please print): _____

Specialty: _____ NPI Number: _____

License Number: _____ State of Licensure: _____

Phone: _____ Fax: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____