Dear Parent/Guardian:

Your child has a medical/religious exemption to vaccination and is not fully immunized. Although your child remains at risk for getting a vaccine preventable disease, IC 20-34-4 permits your child to attend school.

In the event of an outbreak of a vaccine preventable disease for which your child is not fully vaccinated, your child may be excluded from school to protect his/her health and the health of all our students and staff. It is important to understand that with some diseases such as measles, one infected child is an outbreak. The length of time your child will be kept out of school depends on the disease. Your child's exclusion may be as long as 3-4 weeks.

IF your child is excluded from school, your child will also be excluded from school sponsored activities, such as sporting events, dances, and graduation that occur within the exclusion period. The school will notify you when your child can return to school.

Incompletely vaccinated children can be excluded from school due to cases of measles, chickenpox, pertussis, mumps, or any other vaccine preventable disease (at the discretion of the local health officer).

Acknowledgement of Consequences of Incomplete Vaccination

I understand that my child may be excluded from school in the event of an outbreak of a vaccine preventable disease.

I understand that school exclusion includes after-school activities, such as sporting events, dances, and graduation.

I understand that my child may be required to stay home for multiple weeks during an outbreak of a vaccine preventable disease for which he/she is not vaccinated.

Parent's name _____

Signature _____ Date _____

Child's name _____

Rev 10/2015

VACCINE MEDICAL EXEMPTION

State Form 54648 (4-11)
Indiana State Department of Health, Immunization Division

INSTRUCTIONS: *1. This form for any child in grades K – 12 who is unable to receive a vaccine required for school entry due to a medical contraindication.*
2. Complete and sign form. Submitted to school as proof of exemption from required immunization.

Patient Name _____ Date of Birth *(month/day/year)* _____

Parent/Guardian Name _____ Relationship _____

Street Address _____

City _____ ZIP Code _____ Telephone Number _____

General Contraindications to All Vaccines (*Vaccine should **not** be given.*)

Severe allergic reaction (e.g., anaphylaxis) after a previous vaccine dose or to a vaccine component

- ☐ Hepatitis B (Hep B)
- ☐ Diphtheria, tetanus, pertussis (DTaP, Tdap)
- ☐ Tetanus, diphtheria (DT, Td)
- ☐ Inactivated poliovirus (IPV)
- ☐ Measles, mumps, rubella (MMR)
- ☐ Varicella (Var)
- ☐ Meningococcal, conjugate (MCV4) or Meningococcal, polysaccharide (MPSV4)

Which vaccine or vaccine component caused reaction? _____

Type of Clinical Reaction & Date *(month, day year)* _____

Vaccine Specific Contraindications (Vaccine should **not** be given.)

DTaP or Tdap	☐ Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within seven (7) days of administration of previous dose of DTP or DTaP
MMR	☐ Pregnancy Estimated Date of Confinement (EDC): _____ *(month, day year)* ☐ Known severe immunodeficiency (e.g., hematologic and solid tumors; receiving chemotherapy; congenital immunodeficiency; long term immunosuppressive therapy; or patients with HIV infection who are severely immunocompromised)
Varicella	☐ Pregnancy Estimated Date of Confinement (EDC): _____ *(month, day year)* ☐ Substantial suppression of cellular immunity

Vaccine Specific Precautions (*Vaccine may be given or held depending on clinical situation.*)

DTaP or Tdap	☐ Guillan-Barre syndrome (GBS) within six (6) weeks after a previous dose of tetanus-containing vaccine ☐ History of Arthus-type hypersensitivity reaction following a previous dose of tetanus and/or diphtheria toxoid-containing vaccine: defer vaccination until at least ten (10) years have elapsed since the previous dose ☐ Progressive or unstable neurologic disorder, uncontrolled seizures or progressive encephalopathy: defer vaccination with DTaP or Tdap until a treatment regiment has been established and the condition has stabilized
DTaP	☐ Temperature of ≥105F (≥40.5C) within forty-eight (48) hours after vaccination with a previous dose of DTP/DTaP ☐ Collapse and shock-like state (i.e.: hypotonic hyporesponsive episode) within forty-eight (48) hours after previous dose of DTP/DTaP ☐ Seizure or convulsion within three (3) days after receiving a previous dose of DTP/DTaP ☐ Persistent, inconsolable crying lasting three (3) or more hours within forty-eight (48) hours after a previous dose of DTP/DTaP
MMR	☐ Recent (within eleven (11) months) receipt of antibody-containing blood product (interval depends on product) ☐ History of thrombocytopenia or thrombocytopenic purpura
Varicella	☐ Recent (within eleven (11) months) receipt of antibody-containing blood product (interval depends on product) ☐ Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) twenty-four (24) hours before vaccination; if possible, delay resumption of these antiviral drugs for fourteen (14) days after vaccination

Other Medical Contraindication (*Must list vaccine(s) and contraindications individually – continue on back if necessary.*)

Vaccine	Specific Contraindication

Please indicate the duration of the medical exemption, and if and when vaccine can be safely administered.
(Exemption can last for a maximum of one (1) year, and a new form must be completed annually if medical exemption still applies.)

- ☐ Medical exemption is permanent, and will apply for one (1) year from today's date.
- ☐ Medical exemption is temporary (<1 year), and resolution is anticipated by ____/____/____
- ☐ Medical exemption is pregnancy, and Estimated Date of Confinement (EDC) is ____/____/____

Physician Name _____ Physician License Number _____

Office Address _____ Telephone _____

Physician Signature _____ Date *(month, day year)* _____