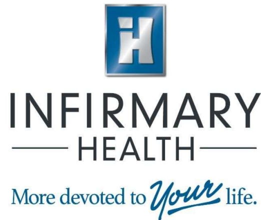
Logged in as E439559 Logout



Medical Exemption Request From Influenza Vaccination

Please print information below:

Name: ______________________ E#: ______________________
Phone #: ______________________ IH Facility: ______________________
Dept. Name: ______________________ Department #: ______________________
Physician Name: ______________________ Physician Phone #: ______________________

This medical declination form must be completed by your primary care physician and then returned to Employee Health.

I understand since I have an evidence-based medical contraindication to influenza vaccination that I will be required to wear a mask when within 6 feet of a patient during a scheduled shift through the duration of the influenza season.

Signature of employee: ______________________ Date: ______________________

This section must be completed by primary care physician

I have evaluated this employee and can verify that he/she has one or more of the following medical contraindications to the influenza vaccine:

- ☐ Documented severe allergy to eggs or egg products
- ☐ Severe allergic reaction to previous influenza vaccine
- ☐ History of Guillain-Barre' Syndrome within six weeks of receiving a previous influenza vaccine
- ☐ Other: (please explain – only evidence-based medical contraindications): ______________________

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Physician Signature: ______________________ Date: ______________________

Signature Stamp NOT Acceptable

Print