Vaccine Preventable Disease Program

GUIDANCE FOR REQUESTING A MEDICAL EXEMPTION FROM MANDATORY IMMUNIZATION

The Department of Health, Vaccine Preventable Disease Program, received inquiries seeking guidance on obtaining medical exemptions from mandatory immunizations for children attending schools, preschools, and child care facilities in New Jersey. Specifically, the Department received questions on what should be included in the medical exemption documentation to ensure that it meets the requirements for the exemptions. In response, the Department is issuing this guidance document to assist healthcare providers, schools, preschools, child care facilities, and local health departments with medical exemptions for mandatory vaccines.

By way of background, N.J.A.C. 8:57 – 4.2 states that a "principal, director or other person in charge of a school, preschool, or child care facility shall not knowingly admit or retain any child whose parents or guardian has not submitted acceptable evidence of the child's immunization," according to the schedules specified in the rules. However, an unvaccinated child may attend a school, preschool, or child care facility if the required vaccination is medically contraindicated for the child. See N.J.A.C. 8:57-4.3. In order to obtain a medical exemption, N.J.A.C. 8:57-4.3 requires a written statement to be submitted to the school, preschool, or child care center by a physician licensed to practice medicine or osteopathy, or an advanced practice nurse who is licensed in any jurisdiction in the United States indicating that the immunization is medically contraindicated for the child for a specific period of time, and the reason(s) for the medical contraindication, based upon valid reasons as enumerated by the Advisory Committee on Immunization Practices (ACIP) of the United States Public Health Service or the American Academy of Pediatrics (AAP) guidelines.

These guidelines are accessible on the CDC and AAP website at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html or https://redbook.solutions.aap.org/redbook.aspx.

To assist treating healthcare providers with submitting adequate and sufficient medical exemption requests that meet the requirements of N.J.A.C. 8:57-4.3, and to guide school, preschools, child care facilities, and local health departments with determining whether an exemption is consistent with the rule requirements, the Department drafted the attached *Request for Medical Exemption from Mandatory Immunization* form that may be used for medical exemptions. Table 1. of the form lists the vaccines that are mandated for children to attend schools, preschools, and child care facilities and current ACIP contraindications and precautions for each vaccine. This form allows the healthcare provider to indicate the vaccine for which the exemption is sought as well as the ACIP contraindication or precaution that is recognized for that specific vaccine and applies to the child. In the event the form does not list the specific contraindication or precaution that exempts the child from a particular vaccine, the form also includes a space marked as "Other" where the healthcare provider may explain, in detail, the contraindication or precaution for the child's receipt of vaccine. The use of "Other" as a contraindication or precaution should be extremely rare, and the contraindication/precaution must be consistent with ACIP guidelines and established national standards for vaccination practices to be accepted. Table 2. of the form lists conditions that are **incorrectly** perceived as contraindications or precautions for vaccines, which provides further guidance to the healthcare provider in determining whether the exemption is valid and medically accepted.

The form will also assist schools, preschools, child care facilities, and local health departments in determining the validity of the exemption and whether it should be accepted or rejected. Specifically, the school, preschool, child care facility, and local health department may accept a medical exemption in which a healthcare provider indicates a contraindication or precaution listed in Table 1. However, a school, preschool, child care facility, and local health department should not accept a medical exemption in which a healthcare provider indicates a condition listed in Table 2.

It should be noted that healthcare providers who submit medical exemptions for mandatory vaccinations must ensure that the information submitted is accurate and verifiable. Supporting medical documentation may be requested by the school, preschool, or child care facility and/or by local or state public health authorities. Healthcare providers who misrepresent medical information may be referred to the New Jersey State Board of Medical Examiners and/or appropriate licensing/ regulatory agency.

If a healthcare provider, school, preschool, or child care facility has questions about medical exemptions, it should direct the questions to the local health department with jurisdiction over the municipality in which the school is located. To locate the local health department, please visit the New Jersey Department of Health website at https://www.nj.gov/health/lh/community/index.shtml#1. Local health departments with questions can directly contact the Vaccine Preventable Disease Program at 609-826-4861.

Please also note that the use of the Form is not a mandate or requirement, but rather a tool that may be used by healthcare providers, schools, preschools, child care facilities, and local health departments in determining the validity of a medical exemption from a mandatory immunization.

INSTRUCTIONS FOR COMPLETION

It is easiest to use the latest version of Adobe Reader DC. If you do not have the latest version, download and install the free software by visiting this webpage: **https://get.adobe.com/reader/**

1. Fill out the form completely. ALL form fields are required except where noted as being optional.
    a. Enter the name of the Student and other identifying information.
    b. Check off each vaccine for which an exemption is requested.
        i. 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.
        ii. Check the ACIP contraindication/precaution applicable for each vaccine for which an exemption is requested.
    c. If the contraindication/precaution is not included in Table 1, please put an “X” next to “Other” and fully explain. Please be sure that the contraindication/precaution does not appear in Table 2, that there is a valid contraindication/precaution noted for each vaccine for which an exemption is requested, and that the contraindication/precaution is consistent with ACIP/AAP guidelines and established national standards for vaccination practices.
2. Sign and date the Attestation Statement
3. Provide a copy to the person requesting the medical exemption or directly to the school, preschool or child care center.
4. Keep a copy of the form for your records.

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Name of Student: *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*	
Patient/Parent Email Address:	

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.

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

Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
☐ **DTaP, Tdap**	☐ Temporary through: ______ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of a previous dose of DTP, DTaP, or Tdap **Precautions** ☐ Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP or Tdap until neurologic status clarified and stabilized ☐ Guillain-Barré syndrome < 6 weeks after previous dose of tetanus-toxoid-containing vaccine ☐ History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid-containing or tetanus toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus toxoid-containing vaccine
☐ **DT, Td**	☐ Temporary through: ______ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component **Precautions** ☐ Guillain-Barré syndrome < 6 weeks after a previous dose of tetanus-toxoid-containing vaccine. ☐ History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria- or tetanus toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid-containing vaccine

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Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
☐ **Haemophilus influenzae type b (Hib)**	☐ Temporary through: ____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
☐ **Hepatitis B (HepB)**	☐ Temporary through: ____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Hypersensitivity to yeast
☐ **Inactivated poliovirus vaccine (IPV)**	☐ Temporary through: ____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component **Precautions** ☐ Pregnancy
☐ **Influenza, inactivated injectable (IIV)**	☐ Temporary through: ____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after previous dose of influenza vaccine or to vaccine component **Precautions** ☐ Guillain-Barré syndrome < 6 weeks after a previous dose of influenza vaccine ☐ Egg allergy other than hives, e.g., angioedema, respiratory distress, lightheadedness, or recurrent emesis; or required epinephrine or another emergency medical intervention (IIV may be administered in an inpatient or outpatient medical setting, under the supervision of a healthcare provider who is able to recognize and manage severe allergic conditions)
☐ **Influenza, recombinant (RIV)**	☐ Temporary through: ____ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) to any component of the vaccine **Precautions** ☐ Guillian-Barré syndrome < 6 weeks after a previous dose of influenza vaccine

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Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
☐ **MMR**	☐ Temporary through: ______ ☐ 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
☐ **Meningococcal (MenACWY)**	☐ Temporary through: ______ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
☐ **Meningococcal (MenB)**	☐ Temporary through: ______ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component **Precautions** ☐ Pregnancy
☐ **Pneumococcal (PCV13)**	☐ Temporary through: ______ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose of PCV13 or any diphtheria-toxoid-containing vaccine or to a component of a vaccine (PCV13 or any diphtheria-toxoid-containing vaccine), including yeast

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Vaccine	Exemption Length	ACIP Contraindications and Precautions (CHECK ALL THAT APPLY)
☐ **Varicella**	☐ Temporary through: ______ ☐ Permanent	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or persons with HIV infection who are severely immunocompromised) ☐ Pregnancy ☐ 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) ☐ Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination; avoid use of these antiviral drugs for 14 days after vaccination) ☐ Use of aspirin or aspirin-containing products
☐ Other. Please explain fully and attach additional sheets as necessary. Please be sure to check Table 2 below to ensure that the condition is not one incorrectly perceived as a contraindication or precaution.		

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 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: ______________

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Table 2. Examples of Conditions incorrectly perceived as contraindications or precautions to vaccination*
(i.e., vaccines may be given under these conditions)

Vaccine	Conditions incorrectly perceived as contraindications and precautions to vaccines (i.e., vaccines may be given under these conditions)
General for MMR, Hib, HepB, Varicella, PCV13, MenACWY	• History of Guillain-Barré syndrome • Recent exposure to an infectious disease • History of penicillin allergy, other nonvaccine allergies, relatives with allergies, or receiving allergen extract immunotherapy
DTaP	• Fever within 48 hours after vaccination with a previous dose of DTP or DTaP • Collapse or shock like state (i.e., hypotonic hyporesponsive episode) within 48 hours after receiving a previous dose of DTP/DTaP • Seizure ≤ 3 days after receiving a previous dose of DTP/DTaP • Persistent, inconsolable crying lasting ≥ 3 hours within 48 hours after receiving a previous dose of DTP/DTaP • Family history of seizures • Family history of sudden infant death syndrome • Family history of an adverse event after DTP/DTaP • Stable neurologic conditions (e.g., cerebral palsy, well-controlled seizures, or developmental delay)
Hepatitis B (HepB)	• Pregnancy • Autoimmune disease (e.g., systemic lupus erythematosus or rheumatoid arthritis)
Influenza, inactivated injectable (IIV)	• Nonsevere (e.g., contact) allergy to latex, thimerosal, or egg
MMR	• Breastfeeding • Pregnancy of recipient's mother or other close or household contact • Recipient is female of child-bearing age • Immunodeficient family member or household contact • Asymptomatic or mildly symptomatic HIV infection • Allergy to eggs
Tdap	• History of fever of ≥ 40.5° C (≥ 105° F) for < 48 hours after vaccination with previous dose of DTP/DTaP • History of collapse or shock-like state (hypotonic hyporesponsive episode) within 48 hours after receiving a previous dose of DTP/DTaP • History of persistent, inconsolable crying lasting > 3 hours within 48 hours of receiving a previous dose of DTP/DTaP • History of extensive limb swelling after DTP/DTaP/Td that is not an Arthus-type reaction • History of stable neurologic disorder • Immunosuppression
Varicella	• Pregnancy of recipient's mother or other close or household contact • Immunodeficient family member or household contact • Asymptomatic or mildly symptomatic HIV infection • Humoral immunodeficiency (e.g., agammaglobulinemia)

* For a complete list of conditions, please review the ACIP Guide to Contraindications and Precautions accessible at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.