UNIVERSITY OF
DETROIT MERCY
COLLEGE OF HEALTH PROFESSIONS & MCAULEY SCHOOL OF NURSING

INFLUENZA VACCINATION: MEDICAL EXEMPTION FORM

First & Last Name: _____ **Date:** _____

Date of Birth: _____ **Phone Number:** _____

Please select all that apply: ☐ Detroit Mercy Student ☐ Detroit Mercy Clinical Instructor

Individuals who have a medical condition that will prevent them from receiving the influenza vaccine must present documentation from their physician or practitioner.

Have you ever had a life-threatening allergic reaction after a dose of Influenza vaccine? ☐ YES ☐ NO

Have you ever had a life-threatening allergic reaction to any of the vaccine ingredients? ☐ YES ☐ NO

If yes, which ingredient? _____

Have you ever had a serious allergic reaction to eggs? ☐ YES ☐ NO

Student / Clinical Instructor Signature: _____

HEALTHCARE PROVIDER TO COMPLETE

A licensed physician/practitioner to complete and sign request for exemption.

Physician/Practitioner Statement: The above-named individual from the University of Detroit Mercy is under my care. I have reviewed the influenza vaccine recommendations from the Centers for Disease Control (CDC) and request the following medical exemption based on a true medical contraindication as outlined by the CDC:

Exemption related to:

- ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose of Influenza vaccine
- ☐ History of anaphylactic reaction to Influenza vaccine ingredient
- ☐ Egg allergy
- ☐ History of Guillain-Barre syndrome
- ☐ Other: _____

Physician/Practitioner Name (Print): _____

Medical License #: _____

Phone: _____ **Date:** _____

Physician/Practitioner Name (Signature): _____