Request for Medical Exemption of Influenza Vaccination

Employee Name (please print) _____

Employee Number _____

Department _____

Phone_____ Date of Birth _____

**Every year, thousands of Americans die from influenza. According to the Centers for Disease Control, more children died of influenza during the 2017-2018 flu season than in any prior flu season. As many as 50% of children who die of influenza are otherwise healthy. Accordingly it is our policy that all employees are vaccinated against influenza on an annual basis to help minimize the risk of exposing our patients and employees to this serious disease, with limited exceptions. With this in mind, Nationwide Children's Hospital feels obligated to understand whether requests for medical exemptions are based on valid medical grounds.

I am requesting an exemption from receiving the 2018-2019 influenza vaccine at Nationwide Children's Hospital because I have a medical condition that prevents me from getting vaccinated.

****Please note**; if you are granted an exemption from receiving the influenza vaccine, you will be required to wear a mask during flu season according to Administrative Policy, I-9 Influenza Vaccination Policy & Procedures.
"Unvaccinated Employees Must Wear Masks During Flu Season: Any NCH employee, student, rotating resident, or volunteer who does not receive an annual influenza vaccine must wear a mask at all times during Flu Season when located in an NCH patient-care area, inpatient or outpatient ancillary area, patient registration area, patient or family waiting area, or any other area designated by the Physician Director of Epidemiology. Masks also must be worn if working in patient food services, NCH gift shops, patient transportation, or if working any job that requires frequent or episodic patient or patient family interaction".

My personal physician (MD, DO, NP, PA) ***must complete page two of this form.***

Employee Signature _____ Date _____

****When completed, return this form to Employee Health no later than November 1, 2018**

Employee Health Use Only:

Approved _____ Not Approved _____ By: _____

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Employee Name (please print) _____

Department _____

Your physician must complete this form to share the medical contraindication for your receipt of the influenza vaccine.

Date _____

I am caring for patient _____ (employee name)

This employee has a known contraindication to receive the vaccine which is: (check box below)

- □ Severe allergic reaction within 24 hours of receiving the influenza vaccine, (hives, swelling of the lips/tongue, shortness of breath). This does not include a sore arm or local reaction or egg allergy (no longer a contraindication).
- □ History of Guillian Barré Syndrome within six weeks of receiving a prior influenza vaccine.
- □ Other-If the reason for medical exemption does not fall into one of the above categories, please submit a separate letter of explanation and why it is a contraindication to receipt of the influenza vaccine.
  ** Pregnancy is not a contraindication for receiving the influenza vaccine. It is recommended to receive an influenza vaccine during every pregnancy

My patient has a contraindication; I request medical exemption. Please consider this exemption as... *(check box below)*

- □ TEMPORARY
- □ PERMANENT

Provider Signature _____
MD, DO, NP, PA (circle credentials)

Provider Print Name _____

Provide Address _____

Provider Phone _____

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