

MEDICAL EXEMPTION: MMR IMMUNIZATION PROVIDER FORM

New York State public health law 2165 and University policy requires that all students document immunity to measles, mumps, and rubella (MMR).

**A medical exemption will be considered upon receipt of a completion of ALL THREE of the following requirements:**

1. Completion of the **St. John's University Request for Medical Exemption: MMR Immunization Form**
2. Completion of the **St. John's University Medical Exemption: MMR Immunization Provider Form (THIS FORM)**
  - a. This form must be filled out completely, in the English Language, from a MD, DO, NP, or PA, whose specialty is appropriate to the associated condition and is not a family member.
  - b. It must include:
    - i. A **specific diagnosis** of the condition or treatment which contraindicates an immunization.
    - ii. Duration of condition/treatment
    - iii. Any medications or other conditions that preclude further immunizations
3. Submission of Measles, Mumps, Rubella (MMR) Titers, which is a blood test that determines immunity. This must be submitted so that the University is aware of the student's immunity status in the event of a MMR outbreak. Exemption approval will not be granted without knowledge of current antibody levels.

**To be Completed by Student or Parent/Guardian:**

Student Name: \_\_\_\_\_ X Number \_\_\_\_\_

University Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you applied for a medical MMR vaccination exemption at St. John's University in the past?

No  Yes (If Yes, please provide the date of your submission:) \_\_\_\_\_

Was your previous medical exemption application granted?  No  Yes

**To be Completed by Student or Parent/Guardian. Initial next to the below statements:**

	I give the representatives from St. John's University permission to speak with the medical provider and/or medical office I have named, regarding my application for medical exemption from the MMR vaccination.
	I certify that the information I have provided on and in connection with this request is accurate and complete.

TO BE COMPLETED BY HEALTH CARE PROVIDER (MD, DO, NP, or PA):

**Directions:**

1. Please review the CDC guidance (<https://www.cdc.gov/vaccines/vpd/mmr/public/index.html>) regarding contraindications for MMR vaccination to assist in determining the medical justification for a medical exemption.
2. Only those individuals meeting criteria for contraindication to the MMR vaccine articulated by the CDC will be considered for medical exemption.
3. Please fill out this form completely, if any fields are left blank, the form will be rejected.

1. Is the Measles, Mumps, Rubella (MMR) Vaccination medically contraindicated at this time?  No  Yes
2. What is the duration of the medical contraindication? (e.g. 1 month): \_\_\_\_\_
3. Please **specify the date** in which the student is permitted to be vaccinated: \_\_\_\_\_

**Medical Provider Certification of Contraindication:** I certify that my patient (named above) should not be vaccinated against Measles, Mumps, & Rubella (MMR) because they have one of the following contraindications:

- Documented anaphylactic allergic reaction to a previous MMR vaccine.

Describe the Specific Reaction and the Date it Occurred:

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- Documented allergy to a component of the vaccine. (Does not include sore arm from the injection, redness where the shot was given, fever, or mild rash as these are common side effects of the vaccine.)

What is the component the student is allergic to? Provide supporting documentation (e.g. allergy testing)

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- Current Pregnancy (specify due date): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

- Documented weakened immune system due to disease (such as cancer or HIV/AIDS) or medical treatments (such as radiation, immunotherapy, steroids, or chemotherapy)

Specify medical condition or medical treatments:

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**Documented that student has a parent, brother, or sister with a history of immune system problems.**

Specify the medical condition affecting their immune system:

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**Documented history of thrombocytopenia or vaccine induced thrombocytopenia**

Specify the date of the diagnosis and attach the Office Visit Note & Lab Report:

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**The student has recently had a blood transfusion or received other blood products within the last 3 months.**

Specify the Date of Transfusion: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Documented history of tuberculosis**

Specify the date of the diagnosis and attach the Office Visit Note & Lab Report:

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**The student has gotten any other vaccines in the past 4 weeks**

Specify the vaccine name and date it was administered:

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**Current moderate or severe illness. (Note: A mild illness, such as cold is usually not a reason to postpone vaccination)**

Specify the moderate or severe illness and your medical justification for postponing vaccination AND **Specify date the student is permitted to be vaccinated:**

**Medical Provider Name:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Profession:**     MD     DO     NP     PA

**License Number:** \_\_\_\_\_

**State of Licensure:** \_\_\_\_\_

**Practice Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Practice Phone Number:** \_\_\_\_\_

**Medical Providers Signature & Stamp (Both Required):** \_\_\_\_\_