THE UNIVERSITY of NEW MEXICO

Student Health & Counseling (SHAC)
Allergy and Immunization Clinic
(505) 277-7925 Fax: (505) 277-7971

Influenza Immunization Medical Exemption Form

Name		Date of Birth	/ /
Email		Phone #	
Clinical Program		Banner ID	

This medical exemption form must be completed by the person's primary licensed healthcare provider and returned to UNM Student Health and Counseling (SHAC) Allergy and Immunization Clinic (A&I) by November 15.

Dear Provider:

UNM Student Health & Counseling recognizes its responsibility to students from the potentially devastating effects of influenza infection. Students in Clinical Health Programs are at greater risk of contracting and spreading influenza. The most effective way to prevent infection from an influenza virus is through annual influenza immunization, which is an immunization requirement for students in healthcare programs at the University of New Mexico.

The above named student is requesting an exemption from this immunization requirement. A medical exemption from influenza immunization may be granted for certain recognized contraindications according to the most recent recommendations provided by the CDC Advisory Committee on Immunization Practices (ACIP) in the MMWR available at www.cdc.gov/mmwr/

Please complete the form below and return to SHAC Allergy and Immunization by fax 505 277-7971 by November 15. Thank you.

I have evaluated and verify that ____ has one or more of the contraindications below and request a medical exemption from the influenza immunization.

- ❍ Documented diagnosis of previous severe allergic reaction to the influenza vaccine or a component of the immunization, including egg allergies. ***Please provide a detailed narrative that describes the event.***
- ❍ Documented diagnosis of Guillain-Barre Syndrome within six weeks of receiving a previous immunization. ***Please provide a detailed narrative that describes the event.***
- ❍ Other—only evidence-based medical contraindications ***Please provide this information in a separate narrative that describes the exemption in detail.***

Clarification from the requesting employee and physician may be requested.

Provider Printed Name____ Date:____________________

Provider Signature____ Medical License # ________________

Clinic Name ____ Clinic Phone Number ______________________

(Note: Signature stamp will not be accepted. An incomplete form will not be accepted.)

DESIGNATED OFFICE USE ONLY:

Medical Exemption

❑ Approved as a ❑ Permanent 1=1 Temporary Condition

❑ Denied

SHAC Approval Signature: ____ Date ______________________