Trinity College Health Center with Care Provided by
Hartford HealthCare, Campus Care
300 Summit Street
Hartford, CT 06106-3100
p) 860.297.2018
f) 860.297.2020
e) healthcenter@trincoll.edu

Trinity College Student Request for Medical Exemption for Immunizations

Student's Name: _____ DOB: _____

Student Directions:

For students requesting a medical exemption from immunization(s) required by Trinity College and the State of Connecticut; this form is a direct, college-age group specific edit of the State of Connecticut's "Student Medical Exemption Certificate for Required Immunizations." Medical contraindications and precautions for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) Comprehensive General Recommendations and Guidelines, published by the Centers for Disease Control and Prevention. All medical exemption requests are reviewed by Health Center staff for approval.

The original form(s) is available at:
https://portal.ct.gov/DPH/Immunizations/Immunizations-Exemptions-Certification-Forms

Please return the completed form (7/7 pages), along with a copy of the student's New Student Form to the Trinity College Health Center either by fax **(860)297-2020** or at **healthcenter@trincoll.edu .**

Student's Full Name:_____

Student's Date of Birth:_____

If student is <18 years old: Parent/ Guardian Name:_____

Parent/ Guardian Phone Number: _____

I am requesting that this medical provider submit documentation that immunization(s) are medically contraindicated.

X_____

Student Signature and Date (& Parent/ Guardian signature if student < 18 years old)

The following is to be completed by your medical provider.

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Student's Name: _____ DOB: _____

Provider Directions:

Part 1. Please complete the demographics section.

Part 2. Please mark the contraindications/precautions that apply to this patient/student (indicate all that apply).

Part 3. If no contraindications or precautions apply in part 2, write a brief explanation of the reason the patient/student requires the exemption.

Part 4. Sign the Statement of Clinical Opinion and date the form.

Attach a copy of the patient/student's most current immunization record.

Part 1

Name of Medical Provider completing form:_____

Provider completing for must be one of the following (please circle): MD/ DO NP/ APRN PA

License Number:_____NPI:_____

Phone #_____Fax#_____

Office Address: _____

Part 2

Please mark the vaccine(s), exemption duration, and all contraindications/precautions that apply to this patient/student for each vaccine.

Medical contraindications and precautions for immunizations are based upon the Advisory Committee on Immunization Practices (ACIP) Comprehensive General Recommendations and Guidelines, published by the Centers for Disease Control and Prevention.

A **contraindication** is a condition in a recipient that increases the risk for a serious vaccine adverse event (VAE) or compromises the ability of the vaccine to produce immunity.

A **precaution** is a condition in a recipient that might increase the risk for a serious VAE or that might compromise the ability of the vaccine to produce immunity. Under normal conditions, vaccinations are deferred when a precaution is self-limiting, but can be administered if the precaution condition improves.

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STATE REQUIRED VACCINATIONS:

Vaccine	Exemption Duration	ACIP Contraindications and Precautions (Check all that apply)
☐ Measles-Mumps-Rubella (MMR)	☐ Temporary through: (mm/ yy) _____ /_____ ☐ Permanent ☐ Not Applicable	*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 (i) or patients with HIV infection who are severely immunocompromised) ☐ Family history of altered immunocompetence (i) *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 (k) ☐ Moderate or severe acute illness with or without fever

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Vaccine	Exemption Duration	ACIP Contraindications and Precautions (Check all that apply)
☐ Varicella	☐ Temporary through:(mm/yy) _____/_____ ☐ Permanent ☐ Not Applicable	*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 (i) or patients with HIV infection who are severely immunocompromised) (g) ☐ Pregnancy ☐ Family history of altered immunocompetence (j) *Precautions* ☐ Recent (<11 months) receipt of antibody-containing blood product (specific interval depends on product) ☐ Moderate or acute illness with or without fever

Vaccine	Exemption Duration	ACIP Contraindications and Precautions (Check all that apply)
☐ Meningococcal conjugate vaccines (MenACWY)	☐ Temporary through: (mm/ yy) _____ /_____ ☐ Permanent ☐ Not Applicable	*Contraindications* ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component, including yeast *Precautions* ☐ Moderate or severe acute illness with or without fever

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Part 3

Other Allergic Reactions/ Other Type of Medical Condition

Complete this section if claiming a medical exemption for a vaccine based on a condition that does not meet any of the ACIP criteria for a contraindication or precaution previously listed.

- Vaccine(s), list all that apply:

  _____

- For each vaccine listed above, select the allergic or other reaction for which medical exemption is being submitted. Please check off any of the following that apply:

☐ This patient has an autoimmune disorder

☐ This patient has a family history of an autoimmune disorder

☐ This patient has a family history of a reaction to a vaccination

☐ This patient has a genetic predisposition to a reaction to a vaccination as determined through genetic testing

☐ This patient has a previous documented reaction that is correlated to a vaccination

☐ Other condition/reaction not listed above (must specify): _____

- Please provide a detailed explanation of the reaction/condition listed above:

  _____

  _____

Part 4

Statement of Clinical Opinion In accord with the legal requirements of Public Act 21-6, the vaccine(s) indicated above is/are in my clinical opinion medically contraindicated for this patient/student due to the physical condition as explained above.

Provider's Signature _____Date _____

"A person may be placed into quarantine or isolation when there are "reasonable grounds to believe [a person] to be infected with, or exposed to, a communicable disease or to be contaminated or exposed to contamination or at reasonable risk of having a communicable disease or being contaminated or passing such communicable disease or contamination to other persons if the commissioner determines that such individual or individuals pose a significant threat to the public health and that quarantine or isolation is necessary and the least restrictive alternative to protect or preserve the public health." Conn. Gen. Stat. § 19a-131b(a)."