GREATER DETROIT AGENCY FOR THE BLIND AND VISUALLY IMPAIRED
COVID-19 VACCINE MEDICAL EXEMPTION FORM


Please check the website to ensure that you are reviewing the most recent CDC/ACIP information. Please note that the presence of a moderate to severe acute illness with or without fever is a precaution to administration of all vaccines. However, as acute illnesses are short-lived, medical exemptions should not be submitted for this indication.

### Table 1. ACIP Contraindications and Precautions to Vaccination for Mandatory Vaccines

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Exemption Length</th>
<th>ACIP Contraindications and Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 Vaccine</td>
<td>Temporary through:</td>
<td>Contraindications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component</td>
</tr>
<tr>
<td></td>
<td>Permanent</td>
<td>Other (explain below)</td>
</tr>
</tbody>
</table>

### Table 2. CDC/ACIP Contraindications and Precautions

Other. Please explain fully and attach additional sheets as necessary.

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**Attestation**

I am a physician (M.D. or D.O) licensed to practice medicine in a jurisdiction of the United States or an advanced practice nurse licensed in a jurisdiction of the United States.

By signing below, I affirm that I have reviewed the current CDC/ACIP Contraindications and Precautions and affirm that the stated contraindication(s)/precaution(s) is enumerated by the CDC/ACIP and consistent with established national standards for vaccination practices. I understand that I might be required to submit supporting medical documentation.

Healthcare Provider Name (please print): ____________________________ Specialty: ____________________________
NPI Number: ____________________________ License Number: ____________________________ State of Licensure: ____________________________
Phone: ____________________________ Fax: ____________________________ Email: ____________________________
Address: ____________________________ City: ____________________________ State: __________________ Zip: __________________
Signature: ____________________________ Date: ____________________________