

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



Employee Name	Date of Birth:
Employee Email Address:	Primary Phone:
Patient/Parent Home Address: <small>address 1</small> <small>address 2</small> <small>city</small> <small>state</small> <small>zip</small>	

Medical contraindications and precautions for immunizations are based on the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP)/CDC, available at

<https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html> or

<https://www.cdc.gov/vaccines/covid-19/index.html> or <https://redbook.solutions.aap.org/redbook.aspx>

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**

Vaccine	Exemption Length	ACIP Contraindications and Precautions
COVID-19 Vaccine	<input type="checkbox"/> Temporary through: <input type="text"/>	<b>Contraindications</b> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Other (explain below)
	<input type="checkbox"/> Permanent	

Vaccine	Exemption Length	CDC/ACIP Contraindications and Precautions
Other. Please explain fully and attach additional sheets as necessary.		

**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: \_\_\_\_\_