thrive
Campus Health Services

James A. Taylor Building
320 Emergency Room Drive
CB# 7470,Chapel Hill, NC 27599
phone 919-966-2281 fax 919-966-0616
campushealth.unc.edu

UNC Health Science Student
MEDICAL VACCINE CONTRAINDICATION Form

I understand that immunizations against measles, mumps, rubella (MMR vaccine), tetanus, diphtheria and acellular pertussis (Tdap vaccine), varicella (or chickenpox), and influenza are an important patient and health care personnel safety issue and are strongly supported by the Centers for Disease Control and Prevention (CDC). Vaccine Information Statements are available at http://www.cdc.gov/vaccines/hcp/vis/index.html. I acknowledge that I have read and am aware of the Vaccine Information Statements regarding each vaccine listed above.

I understand that, if I refuse one or more of the vaccines and am exposed to the disease(s) the vaccination(s) are given to prevent, I may not be allowed to return to work or school during the incubation period. UNC Health Care requires that I receive the above vaccination(s) as a condition of employment, or as a Health Care Personnel providing services to UNC Healthcare patients.

Despite my understanding of the facts set forth above, I decline the vaccine(s) checked below because I hereby certify and confirm that I have a medical contraindication to (check all that apply):

☐ **MMR (measles, mumps, rubella)** **Severe contraindications include:** • **Severe allergic reaction after a previous dose or to a vaccine component** • **Pregnancy** • **Known severe immunodeficiency**	☐ **Varicella (or chickenpox) Vaccine** **Severe contraindications include:** • **Severe allergic reaction after a previous dose or to a vaccine component** • **Substantial suppression of cellular immunity** • **Pregnancy**
☐ **Tdap (tetanus, diphtheria and acellular pertussis)** **Severe contraindications include:** • **Severe allergic reaction after a previous dose or to a vaccine component** • **Severe allergy to latex** • **Encephalopathy within seven days after receipt of a previous dose of DTP or DTaP**	☐ **Influenza Vaccine** **Severe contraindications include:** • **Severe (anaphylactic) reaction to eggs** • **Severe allergy to another component of the vaccine. Package insert should be consulted for list of components of the vaccine** • **Severe allergy to a prior dose of a seasonal influenza vaccine** **Precautions include:** • **Guillain-Barre Syndrome (GBS) within 6 weeks of a previous dose of an influenza vaccine** • **Presence of a moderate or severe acute illness with or without fever**

Please specify the nature of your medical contraindication:

I understand that I must be absolutely truthful regarding any objection I make to receive the vaccination(s). I understand that I must provide written documentation from my personal health care provider regarding any medical contraindications. I understand that this form will be reviewed by Campus Health Services and Health Science School personnel. I have read and fully understand the information on this declination form.

Student Name (Print): _____ Date: _____

Signature: _____ PID #: _____ Phone#:_____

School Affiliation: □ Dental □ Laboratory Sciences □ Medical □ Nursing □ Pharmacy □ PT/OT □ Other _____

Personal Health Care Provider Signature: _____ Date Reviewed: _____

Reviewer Signature: _____ Date Reviewed: _____

Date Updated: 6/2015