



# UNC Health Science Student Medical Contraindication Vaccine Form

I understand that immunizations against Measles, Mumps, Rubella (MMR vaccine), Hepatitis B, 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.**

**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):**

<input type="checkbox"/> MMR (measles, mumps, rubella) Severe contraindications include: <ul style="list-style-type: none"><li>• Severe allergic reaction after a previous dose or to a vaccine component</li><li>• Pregnancy</li><li>• Known severe immunodeficiency</li></ul>	<input type="checkbox"/> Varicella (or chickenpox) Vaccine Severe contraindications include: <ul style="list-style-type: none"><li>• Severe allergic reaction after a previous dose or to a vaccine component</li><li>• Substantial suppression of cellular immunity</li><li>• Pregnancy</li></ul>
<input type="checkbox"/> Tdap (tetanus, diphtheria and acellular pertussis) Severe contraindications include: <ul style="list-style-type: none"><li>• Severe allergic reaction after a previous dose or to a vaccine component</li><li>• Severe allergy to latex</li><li>• Encephalopathy within seven days after receipt of a previous dose of DTP or DTap</li></ul>	<input type="checkbox"/> Influenza Vaccine Severe contraindications include: <ul style="list-style-type: none"><li>• Severe (anaphylactic) reaction to eggs</li><li>• Severe allergy to another component of the vaccine. Package insert should be consulted for list of components of the vaccine</li><li>• Severe allergy to a prior dose of a seasonal influenza vaccine</li></ul> Precautions include: <ul style="list-style-type: none"><li>• Guillain-Barre Syndrome (GBS) within 6 weeks of a previous dose of an influenza vaccine</li><li>• Presence of a moderate or severe acute illness with or without fever</li></ul>
<input type="checkbox"/> Hepatitis B Severe contraindications include: <ul style="list-style-type: none"><li>• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component</li><li>• Hypersensitivity to yeast</li></ul>	

**Please specify the nature of your medical contraindication:**

I understand that I must be 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 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: \_\_\_\_\_