Medical Exemption Request Form for Influenza Vaccination

Legal Name: _____ University/College:_____
Date of birth or employee /student ID#: _____Program:_____

Work number: _____
Personal phone#: _____
Home address:_____

Email: _____

Facility: _____
Employee unit/department: _____

Shift: __Days __Nights

Personal Physician Name: _____
Physician Phone Number: _____

Please answer the following questions to help us understand the reasons for requesting a Medical Exemption to the flu vaccine:

1. Have you had a flu vaccine before? __Yes __No
2. If yes, did you receive a flu vaccine injection or mist? __Injection __Mist
3. If you have had the flu vaccine when was the last time you were vaccinated to the best of your recollection?
   Year of last influenza vaccination: _____
4. Do you have an egg allergy? __Yes __No (if no, skip to question 7)
   If yes, check all of the following conditions that you experienced
   __I don't eat eggs or egg products
   __Severe allergic reaction from eggs/egg products
   __Tongue Swelling
   __Nausea/vomiting
   __Rash and or hives
   __Respiratory difficulty
   __Other _____
5. Was your reaction severe enough to seek medical attention? __Yes __No

Employee/Student name:_____

6. If yes, where was your reaction treated? (check all that apply)

__Home
__Physician office
__Emergency room
__Urgent Care
__Hospital

7. Do you have an allergy to components of the vaccine or other adverse reaction to flu vaccine? Yes___ No___
   a. If yes, identify component of vaccine that you are allergic to:
      __Component unknown
      __Other: _____

8. If yes, check all the following conditions that you experienced
   __Anaphylactic reaction
   __Tongue Swelling
   __Rash and or hives
   __Pain, redness or swelling at injection site
   __Decreased range of motion in arm
   __Fever
   __Respiratory difficulty
   __Nausea/vomiting
   __Serum Sickness
   __Flu like illness that left you unable to work (describe symptoms and duration)
   _____
   __Allergies to other medications (list medication)
   _____
   _____

   __Headache/migraine
   __Guillain-Barre' Syndrome (a severe paralytic syndrome) within 6 weeks of vaccination
   __Other: _____

9. Was your reaction severe enough to seek medical attention? __Yes __No

Employee/Student name:_____

10. If yes, where was your reaction treated? (check all that apply)
    __Home
    __Physician office
    __Emergency room
    __Urgent Care
    __Hospital

11. Is there any another reason you feel you should receive a medical exemption from the flu vaccine? Please explain with as much detail as possible to the specific symptoms / concerns you have.

    _____

    _____

I will be submitting additional information to Employee Health Services (Volunteer Services if you are a student) by fax? __Yes __No

I authorize Union Hospital, Inc. to contact the physician listed above to clarify the medical reason(s) I have given for not wanting to take the influenza vaccine. Additionally, I understand that once the physician listed above has provided this information, it can be used to assist the Union Hospital, Inc. influenza Medical Exemption Committee in making their decision to approve or deny my exemption request, and this information will be kept in my confidential Employee Health file. I may request a copy of my signed authorization if desired. I understand that I may revoke this authorization at any time unless this authorization has already been carried out and your physician has provided the information requested. This authorization will expire when I am no longer employed by Union Hospital, Inc. or any of its affiliated entities if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this authorization, I must mail, fax, or bring a letter in person to the Employee Health Department where I received the influenza vaccination stating that I want to cancel this authorization.

Employee/Student Signature: _____ _Date:_____

Medical Provider Signature: _____Date: _____

Internal Use Only:

[ ] Exemption approved [ ] Exemption Denied [ ] Further clarification needed

If approved:
[ ] Temporary Exemption (for this year only) [ ] Permanent Exemption

Employee/Student name:_____

Clarification needed:

_____

_____

[ ] Employee/Student requested to provide supporting documentation
[ ] Personal physician contacted for further clarification

Date notification sent to employee/student: _____

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Flu Exemption Committee Representative's signature:_____

Union Health Employees: Submit to the Employee Health Department or fax to Employee Health at 812-238-7287.

Students: Submit hard copies to Volunteer Services by:_____
Thank you