Flu Vaccination Medical Exemption Form

UMMS staff member: After the form below has been filled out by your treating medical provider, please visit **umms.org/FluVaxExemptions** to complete an online declination and to upload this completed Medical Exemption Form or other documentation from your medical provider.

Employee Name		Date of Birth	
UMMS Member Org.		Employee ID	
Job Title		Name of Supervisor	
Email Address		Phone Number	

Dear Provider,

The University of Maryland Medical System (UMMS) and its member organizations require staff to be vaccinated with the influenza vaccine, which has been shown to be safe and effective. Healthcare worker vaccination is critical to our fight against influenza. Influenza is highly contagious and an infected healthcare worker could unknowingly spread it to vulnerable patients and other workers before realizing they are sick.

The above-named person is requesting an exemption from this vaccination requirement. If there is a medical contraindication or other appropriate medical reason why your patient cannot receive the influenza vaccine, please complete the form below.

The above person should not be immunized for influenza for the following reasons (Check all that apply):

__ History of severe or life-threatening allergic reaction (anaphylaxis) to any flu vaccine

__ History of severe allergic reaction to any component of the vaccine except egg. Egg allergy is no longer a contraindication to vaccination and thus is not an acceptable reason for exemption. If you have an egg allergy, please check with your Employee Health department regarding use of an egg-free vaccine *or* to see if a special protocol is required for egg-containing vaccine (depending on prior reaction). Visit **umms.org/FluVaxTypes** for a list of vaccine components and to view what flu vaccines are being offered at each hospital.

__ History of Guillain-Barre Syndrome

__ Other. Please provide this information in a separate document that describes the exception in detail. These requests are reviewed on a case-by-case basis.

Provider Name (please print): ______________________________ Phone: ____________________

Provider Signature: ______________________________ Date: ____________________

Provider Medical License Number: ______________________________

Last updated: 9/6/2022