Please have your medical provider complete the below form.

I certify that my patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has a contraindication that warrants a medical exemption from the following:

**Flu Vaccine** is contraindicated due to:

* Documented anaphylaxis or life-threatening allergic reaction to prior flu vaccine or any of the vaccine components.\*
* Guillain-Barré Syndrome within six weeks of prior flu vaccine.
* Other Severe Reaction or medical condition.

Please specify reaction/condition:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**COVID-19 Vaccine\*\*** is contraindicated due to:

* Documented anaphylaxis or life-threatening allergic reaction to prior COVID vaccine or any of the vaccine components.\*
* Pregnancy (deferral)
* Other Severe Reaction or medical condition

Please specify reaction/condition:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\* Documented anaphylactic or life-threatening allergic reaction or other severe adverse reaction generally does not include gastro-intestinal symptoms, sore arm, local reaction, or subsequent respiratory tract infection as the sole presentation of allergy.

\*\* *Atrium Health offers all COVID-19 vaccine options.*

I do hereby attest that this medical exemption is based upon true and accurate medical information that I have as this person’s medical provider.

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Provider Name (Please Print)                                    MD  DO  PA  NP CNM (Circle One)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Provider Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Provider Location

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Provider Telephone