

Instructions for	r completing Medical Exemption Form:										
Section 1: Completed by parent/guardian or student (aged >18 years): Enter child care facility, school, or post-secondary school, and student information											
Section 2: Co											
СС	omplete duration of exemption										
Section 1: Child Care Facility, School, Post-Secondary School, and Student Information											
Student's Nar	ne:	Student's Date of Birth:	Student's Date of Birth:								
Student's Hor	me Address	City	State	Zip							
Name of Child	d Care Facility, School, Post-Secondary School	Street Address	City	Zip							
	· · · · · · · · · · · · · · · · · · ·		/	1-							
I understand that if at any time there is, in the opinion of the Department of Health, danger of an outbreak or epidemic from any communicable disease for which											
immunization is required, this exemption from immunization shall not be recognized and the student named above will be excluded from attending the child care											
facility, school, or post-secondary school until the Director of Health has determined that the presence of the outbreak no longer exists [HRS §302A-1157].											
,, , , , , , , , , , , , , , , , , , ,											
Parent/Guardia	an Name [if student <18 years]. (Please print):										
Parent/Guardia	an or Student (if aged <u>></u> 18 years) Signature:	Date	2:								
Section 2: Fo	r Health Care Provider Use ONLY (MD, DO, ND, APRN-Rx,	PA):									
VACCINE	CONTRAINDICATIONS* (Check all that apply to this patient):	PRECAUTIONS* (Check all that apply to this patient)	FROM:	To:							
DTaP	Severe allergic reaction (e.g., anaphylaxis) after a	□ Guillain-Barre Syndrome <6 weeks after previous	1 1	/ /							
	previous dose or to a vaccine component	dose of tetanus-toxoid-containing vaccine	/ /	/ /							
🗆 Tdap	DTaP/Tdap only : Encephalopathy (e.g., coma,	History of Arthus-type hypersensitivity reactions									
	decreased level of consciousness, prolonged	after a previous dose of diphtheria-toxoid-									
🗆 DT, Td	seizures), not attributable to another identifiable	containing or tetanus-toxoid-containing vaccine									
-	cause, within 7 days of administration of previous	Moderate or severe acute illness with or without									
	dose of DTP, DTaP, Tdap	fever									
		DTaP/Tdap only: Progressive or unstable									
		neurologic disorder, including infantile spasms,									
		uncontrolled epilepsy, progressive encephalopathy									
🗆 Hib	Severe allergic reaction (e.g., anaphylaxis) after a	Moderate or severe acute illness with or without	/ /	/ /							
	previous dose or to a vaccine component	fever									
—	□ Age <6 weeks		, , ,								
🗆 Нер А	Severe allergic reaction (e.g., anaphylaxis) after a	Moderate or severe acute illness with or without	/ /	/ /							
	previous dose or to a vaccine component	fever									
□ Hep A □ Hep B	previous dose or to a vaccine componentSevere allergic reaction (e.g., anaphylaxis) after a	feverImage: DescriptionModerate or severe acute illness with or without		/ /							
	previous dose or to a vaccine component	fever									

*https://health.hawaii.gov/docd/files/2019/08/HAR11-157_EXHIBIT_B.pdf

Student's Date of Birth: _____

Section 2: For Health Care Provider Use ONLY (MD, DO, ND, APRN-Rx, PA):											
VACCINE	CONTRAINDICATIONS* (Check all that apply to this Patient):		PRECAUTIONS* (Check all that apply to this patient)			ом:	To:				
🗆 НРV		evere allergic reaction (e.g., anaphylaxis) after a revious dose or to a vaccine component		5 ,	/	/					
				fever							
		evere allergic reaction (e.g., anaphylaxis) after a		Recent (<11 months) receipt of antibody-	/	/	/ /				
		revious dose or to a vaccine component		containing blood product							
		regnancy		History of thrombocytopenia or							
		nown severe immunodeficiency (e.g., from		thrombocytopenic purpura							
		ematologic and solid tumors, receipt of		Need for tuberculin skin testing or interferon-							
		hemotherapy, congenital immunodeficiency, long-		gamma release assay (IGRA) testing							
		erm immunosuppressive therapy or patients with		Moderate or severe acute illness with or without							
		IIV infection who are severely immunocompromised)		fever							
		amily history of altered immunocompetence									
🗆 мсv		evere allergic reaction (e.g., anaphylaxis) after a		Moderate or severe acute illness with or without	/	/	/ /				
	-	revious dose or to a vaccine component		fever							
D PCV		evere allergic reaction (e.g., anaphylaxis) after a		Moderate or severe acute illness with or without	/	/	/ /				
	-	revious dose of PCV13 or any diphtheria-toxoid-		fever							
		ontaining vaccine or to a component of a vaccine									
	-	PCV13 or any diphtheria-toxoid-containing vaccine)									
🗆 IPV		evere allergic reaction (e.g., anaphylaxis) after a			/	/	/ /				
	р	revious dose or to a vaccine component		Moderate or severe acute illness with or without fever							
Varicella		evere allergic reaction (e.g., anaphylaxis) after a		Recent (<11 months) receipt of antibody-containing	/	/	/ /				
		revious dose or to a vaccine component	_	blood product							
		nown severe immunodeficiency (e.g., from	ш	Moderate or severe acute illness with or without							
		ematologic and solid tumors, receipt of	_	fever							
		hemotherapy, congenital immunodeficiency, long-		Receipt of specific antiviral drugs (acyclovir,							
		erm immunosuppressive therapy or patients with HIV		famciclovir, or valacyclovir) 24 hours before							
		nfection who are severely immunocompromised) regnancy		vaccination Use of aspirin or aspirin-containing products							
		•		Use of aspirin of aspirin-containing products							
Family history of altered immunocompetence Family history of altered immunocompetence Family that in my medical judgement, due to the contraindication(s)/precaution(s) noted above, this student is exempt from the specific vaccine(s) named for											
the period indicated.											
Health care provider's name/Title (Please Print): License number:											
Address:											
Health care provider's signature: Date:											
	Give completed original form to parent/guardian or student (aged \geq 18 years). Send <u>copy</u> of form to: State of Hawaii Department of Health, Immunization										
Branch, P.O. Box 3378, Honolulu, HI 96801 OR Fax to (808) 586-8347.											
DTaP=Diphtheria, Tetanus, acellular Pertussis, Tdap=Tetanus, diphtheria, acellular pertussis, DT=diphtheria, tetanus, Td=tetanus, diphtheria, Hib=Haemophilus influenzae type B, Hep A=hepatitis A,											

DTaP=Diphtheria, Tetanus, acellular Pertussis, Tdap=Tetanus, diphtheria, acellular pertussis, DT=diphtheria, tetanus, Td=tetanus, diphtheria, Hib=*Haemophilus influenzae* type B, Hep A=hepatitis A, Hep B=hepatitis B, HPV=human papillomavirus, MMR=measles, mumps, rubella, MCV=meningococcal conjugate vaccine, PCV=pneumococcal conjugate vaccine, IPV=inactivated poliovirus vaccine