Baylor University

Request for Medical Accommodation – Vaccine Contraindication Form
To Be Completed by a Licensed Provider

Part 1: *To be completed by the student requesting the accommodation*

Name	BU ID	Date of Request

Baylor University Health Services is committed to providing a safe, inclusive, and supportive experience for all and recognizes a medical accommodation may be necessary for certain vaccination requirements. Baylor University Health Services will carefully review all requests for accommodation. Approval is not guaranteed and may be denied if it is determined that approval of the exemption poses a direct threat to the health and safety of Health Service's staff and its patients or if it would otherwise create an undue hardship.

This form is to be used to apply for a medical accommodation. This form must be completed and submitted to health_services@baylor.edu.

You will be notified in writing of the outcome of this request. Please note that your Request for Accommodation will be submitted to Baylor's Medical Director of Health Services for review, and that additional supporting documentation for your request may be required. You hereby consent to the release of this request and any supporting documentation to Medical Director or any other representatives of Health Services on a need-to-know basis in order for the representatives to carry out their duties and to act on your request for an exemption.

Part 2: *To be completed by the treating provider*

Your patient, _____, has requested a medical accommodation for vaccine requirements.

Your patient as communicated that they have a disability that prevents them from having certain vaccine(s) administered. Health Services has engaged in a flexible, interactive process to analyze and evaluate your patient's request for an accommodation under the Americans with Disabilities Act (ADA). If applicable, please indicate which specific vaccine contraindications specified by the Advisory Committee on Immunization Practices (ACIP)/Centers for Disease Control and Prevention (CDC) apply to your patient as listed below.

Hepatitis A Vaccine

_____ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the Hepatitis A vaccine

Hepatitis B Vaccine

_____ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the Hepatitis B vaccine

_____ Hypersensitivity to yeast

Influenza

_____ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the influenza vaccine

Meningococcal

_____ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the meningococcal vaccine

Measles, Mumps, and Rubella (MMR)

_____ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the MMR vaccine

_____ Pregnancy

_____ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised)

_____ Family history of altered immunocompetence

Tetanus, Diphtheria, and Pertussis (Tdap)

_____ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of

the Tdap vaccine

_____ Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures), not attributable to another identifiable cause, within 7 days of administration of previous dose of DTD, DTaP, or Tdap

Varicella

_____ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the Varicella vaccine

_____ Pregnancy

_____ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised)

_____ Family history of altered immunocompetence

Does your patient have a medical condition/disability that prevents them from receiving any vaccination(s)?

_____ No (if no, sign and date the bottom of page)

_____ Yes (if yes, continue with questions below)

Please indicate the medical condition that prevents your patient from receiving the vaccination(s).

If your patient is medically unable to receive a specific vaccination, indicate the vaccination(s) your patient is unable to receive.

Is this a temporary or permanent medical condition/disability?

_____ Temporary and will be able to receive vaccination(s) on _____

_____ Permanent

I, as the patient's provider, attest that the above selected reasons are verified contraindications for my patient.

_____ _____

Provider Signature Date

Provider Printed Name and Title	License Number