



REQUEST For MMR IMMUNIZATION FORM

New York State public health law 2165 and University policy requires that all students' document immunity to measles, mumps, and rubella (MMR).

A medical exemption will be considered upon receipt of completion of both of the following requirements:

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| <ol style="list-style-type: none"> 1. Completion of the Hofstra University Request for Medical Exemption: MMR Immunization Form 2. Completion of the Hofstra University Medical Exemption: MMR Immunization Provider Form (THIS FORM) <ol style="list-style-type: none"> a. This form must be filled out completely, in the English Language, from a MD, DO, NP, or PA, whose specialty is appropriate to the associated condition and is not a family member. b. It must include: <ol style="list-style-type: none"> i. A specific diagnosis of the condition or treatment which contraindicates an immunization. ii. Duration of condition/treatment iii. Any medications or other conditions that preclude further immunizations |
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To be Completed by Student or Parent/Guardian:

Student Name: _____	Hofstra ID _____
University Email: _____	Phone: _____
Have you applied for a medical MMR vaccination exemption at Hofstra University in the past?	
<input type="checkbox"/> No <input type="checkbox"/> Yes (If Yes, please provide the date of your submission:) _____	
Was your previous medical exemption application granted? <input type="checkbox"/> No <input type="checkbox"/> Yes	

To be Completed by Student or Parent/Guardian. Initial next to the below statements:

	I give the representatives from Hofstra University permission to speak with the medical provider and/or medical office I have named, regarding my application for medical exemption from the MMR vaccination.
	I certify that the information I have provided on and in connection with this request is accurate and complete.

TO BE COMPLETED BY HEALTH CARE PROVIDER (MD, DO, NP, or PA):

Directions:

1. Please review the CDC guidance (<https://www.cdc.gov/vaccines/vpd/mmr/public/index.html>) regarding contraindications for MMR vaccination to assist in determining the medical justification for a medical exemption.
2. Only those individuals meeting criteria for contraindication to the MMR vaccine articulated by the CDC will be considered for medical exemption.
3. Please fill out this form completely, if any fields are left blank, the form will be rejected.

1. Is the Measles, Mumps, Rubella (MMR) Vaccination medically contraindicated at this time? No Yes
2. What is the duration of the medical contraindication? (e.g. 1 month): _____
3. Please **specify the date** in which the student is permitted to be vaccinated: _____

Medical Provider Certification of Contraindication: I certify that my patient (named above) should not be vaccinated against Measles, Mumps, & Rubella (MMR) because they have one of the following contraindications:

- Documented anaphylactic allergic reaction to a previous MMR vaccine.

Describe the Specific Reaction and the Date it Occurred:

- Documented allergy to a component of the vaccine. (Does not include sore arm from the injection, redness where the shot was given, fever, or mild rash as these are common side effects of the vaccine.)

What is the component the student is allergic to? Provide supporting documentation (e.g. allergy testing)

- Current Pregnancy (specify due date): _____/_____/_____

- Documented weakened immune system due to disease (such as cancer or HIV/AIDS) or medical treatments (such as radiation, immunotherapy, steroids, or chemotherapy)

Specify medical condition or medical treatments:

Documented that student has a parent, brother, or sister with a history of immune system problems.

Specify the medical condition affecting their immune system:

Documented history of thrombocytopenia or vaccine induced thrombocytopenia

Specify the date of the diagnosis and attach the Office Visit Note & Lab Report:

The student has recently had a blood transfusion or received other blood products within the last 3 months.

Specify the Date of Transfusion: ____/____/____

Documented history of tuberculosis

Specify the date of the diagnosis and attach the Office Visit Note & Lab Report:

The student has gotten any other vaccines in the past 4 weeks

Specify the vaccine name and date it was administered:

Current moderate or severe illness. (Note: A mild illness, such as cold is usually not a reason to postpone vaccination)

Specify the moderate or severe illness and your medical justification for postponing vaccination AND **Specify date the student is permitted to be vaccinated:**

Medical Provider Name: _____ **Date:** ____/____/____

Profession: MD DO NP PA

License Number: _____

State of Licensure: _____

Practice Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Practice Phone Number: _____

Medical Providers Signature & Stamp (Both Required): _____