

Student Name: _____ School: _____ Student Phone #: _____

Physician Name: _____ Physician Phone #: _____

Address: _____ State License Number: _____

Dear Physician:

In 2011, as a patient safety initiative, Aurora Health Care began requiring influenza vaccinations for all of its employees, similar to other required vaccinations such as MMR. For decades, influenza vaccination has been recommended for health care workers and has been shown in study settings to be effective in protecting patients. Your patient is requesting to be exempt from this vaccination. **Medical exemption from influenza vaccination is allowed ONLY for recognized contraindications** (CDC. Prevention and control of seasonal influenza with vaccines: Recommendations of the advisory committee on immunization practices (ACIP). MMWR August 18, 2011/ 60(Early Release);1-6). Please complete the information below regarding your patient's request for a medical exemption. Should you have any questions, please call Aurora's Employee Health and Wellness department at 920-893-4769.

Thank you,

Kathy Leonhardt, MD, MPH
Vice President / Patient Safety Officer
Office of Patient Experience
Aurora Health Care

David R. Smith, MD, MPH
Vice President / Care Management
Office of Patient Experience
Aurora Health Care

Clarification from the requesting employee may be requested in writing or by phone.

My patient should not be vaccinated against influenza for the following reason:

- Recognized contraindication to influenza vaccination (please mark all that apply):
- Severe allergic reaction to eggs. Date of reaction: _____
 - Defined as developing hives, swelling of the lips or tongue, difficulty breathing.
 - Does not generally result in only gastro-intestinal symptoms.
 - The amount of egg protein in influenza vaccines is extremely small. People who can tolerate eating lightly cooked egg, such as a scrambled egg, can generally tolerate the influenza vaccine.
 - History of previous severe allergic reaction to the influenza vaccine or component of the vaccine. Date of reaction: _____
 - Defined as developing hives, swelling of the lips or tongue, difficulty breathing.
 - Does not include sore arm, local reaction or subsequent upper respiratory tract infection.
 - History of Guillan-Barre syndrome within six (6) weeks of receiving a previous vaccine. Date of reaction: _____
 - People with this history can choose to receive the vaccine.
 - Bone marrow transplant within the previous six (6) months. Date of transplant: _____
- Other. Please describe in space below. (These requests will be reviewed on a case-by-case basis by the vice presidents of the Office of Patient Experience.)
- _____
- _____

I certify that my patient has the above contraindication and request medical exemption from the influenza vaccination.

Physician signature: _____ Date: _____
(Signature stamps will not be accepted.)

I hereby authorize the Employee Health and Wellness department to release information to my manager/supervisor to confirm that I am exempt from the influenza vaccination requirement in accordance with policies established by Aurora Health Care. The specific reason for exemption will not be disclosed to my manager/supervisor.

I understand that once this information has been released pursuant to this authorization, it may no longer be protected by federal and/or state law/regulations. I may request a copy of my signed authorization if desired. I authorize the vice presidents of the Office of Patient Experience to contact my physician for clarification of any exemption request.

I understand that I may revoke this authorization at any time, except to the extent that prior action has been taken in reliance on this authorization. This authorization will expire when I am no longer employed by or otherwise affiliated with Aurora Health Care or any of its affiliated entities, facilities or operations, if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this authorization, I must mail, fax or bring a letter in person to the Employee Health and Wellness department where I received the influenza vaccination, stating that I want to cancel this authorization.

Employee Signature: _____ Date: _____