



Medical Exemption Request Form for Influenza Vaccination

Legal Name: _____ University/College: _____

Date of birth or employee /student ID#: _____ Program: _____

Work number: _____

Personal phone#: _____

Home address: _____

Email: _____

Facility: _____

Employee unit/department: _____

Shift: ___Days ___Nights

Personal Physician Name: _____

Physician Phone Number: _____

Please answer the following questions to help us understand the reasons for requesting a Medical Exemption to the flu vaccine:

1. Have you had a flu vaccine before? ___Yes ___No
2. If yes, did you receive a flu vaccine injection or mist? ___Injection ___Mist
3. If you have had the flu vaccine when was the last time you were vaccinated to the best of your recollection?
Year of last influenza vaccination: _____
4. Do you have an egg allergy? ___Yes ___No (if no, skip to question 7)
If yes, check all of the following conditions that you experienced
___I don't eat eggs or egg products
___Severe allergic reaction from eggs/egg products
___Tongue Swelling
___Nausea/vomiting
___Rash and or hives
___Respiratory difficulty
___Other _____
5. Was your reaction severe enough to seek medical attention? ___Yes ___No

Employee/Student name: _____

6. If yes, where was your reaction treated? (check all that apply)

- ☐ Home
- ☐ Physician office
- ☐ Emergency room
- ☐ Urgent Care
- ☐ Hospital

7. Do you have an allergy to components of the vaccine or other adverse reaction to flu vaccine? Yes ☐ No ☐

a. If yes, identify component of vaccine that you are allergic to:

- ☐ Component unknown
- ☐ Other: _____

8. If yes, check all the following conditions that you experienced

- ☐ Anaphylactic reaction
- ☐ Tongue Swelling
- ☐ Rash and or hives
- ☐ Pain, redness or swelling at injection site
- ☐ Decreased range of motion in arm
- ☐ Fever
- ☐ Respiratory difficulty
- ☐ Nausea/vomiting
- ☐ Serum Sickness
- ☐ Flu like illness that left you unable to work (describe symptoms and duration)

- ☐ Allergies to other medications (list medication)

- ☐ Headache/migraine
- ☐ Guillain-Barre' Syndrome (a severe paralytic syndrome) within 6 weeks of vaccination
- ☐ Other: _____

9. Was your reaction severe enough to seek medical attention? ☐ Yes ☐ No

Employee/Student name: _____

10. If yes, where was your reaction treated? (check all that apply)

- ☐ Home
- ☐ Physician office
- ☐ Emergency room
- ☐ Urgent Care
- ☐ Hospital

11. Is there any another reason you feel you should receive a medical exemption from the flu vaccine? Please explain with as much detail as possible to the specific symptoms / concerns you have.

I will be submitting additional information to Employee Health Services (Volunteer Services if you are a student) by fax? ☐ Yes ☐ No

I authorize Union Hospital, Inc. to contact the physician listed above to clarify the medical reason(s) I have given for not wanting to take the influenza vaccine. Additionally, I understand that once the physician listed above has provided this information, it can be used to assist the Union Hospital, Inc. influenza Medical Exemption Committee in making their decision to approve or deny my exemption request, and this information will be kept in my confidential Employee Health file. I may request a copy of my signed authorization if desired. I understand that I may revoke this authorization at any time unless this authorization has already been carried out and your physician has provided the information requested. This authorization will expire when I am no longer employed by Union Hospital, Inc. or any of its affiliated entities 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 Department where I received the influenza vaccination stating that I want to cancel this authorization.

Employee/Student Signature: _____ Date: _____

Medical Provider Signature: _____ Date: _____

Internal Use Only:

☐ Exemption approved ☐ Exemption Denied ☐ Further clarification needed

If approved:

☐ Temporary Exemption (for this year only) ☐ Permanent Exemption

Employee/Student name: _____

Clarification needed:

☐ Employee/Student requested to provide supporting documentation

☐ Personal physician contacted for further clarification

Date notification sent to employee/student: _____

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Flu Exemption Committee Representative's signature: _____

Union Health Employees: Submit to the Employee Health Department or fax to Employee Health at 812-238-7287.

Students: Submit hard copies to Volunteer Services by: _____

Thank you