

Employee Name

Date

Employee number

Dear Medical Provider: As a patient safety initiative, Genesis HealthCare System requires influenza vaccinations for all employees. Your patient is requesting to be exempt from this vaccination.

The following are **not** considered contraindications to influenza vaccination:

- Minor acute illness (e.g., diarrhea and minor upper respiratory tract illnesses, including otitis media).
- Mild to moderate local reactions and/or low-grade or moderate fever following a prior dose of the vaccine.
- Sensitivity to a vaccine component (e.g. soreness, redness, itching, swelling at the injection site).
- Current antimicrobial therapy.
- Disease exposure or convalescence.
- Pregnant or immunosuppressed person in the household.
- Breastfeeding.
- Family history.
- Egg allergy.

Please select one of the following reasons for a medical exemption:

Contraindications to influenza vaccines include the following:

Personal history of a **severe**, life-threatening allergy to any ingredient in a flu vaccine (other than egg proteins).

Personal history of a **severe** allergic reaction to a dose of influenza vaccine.

A severe allergic reaction is characterized by a sudden or gradual onset of generalized itching or erythema (redness), hives; angioedema (swelling of the lips, face or throat); severe bronchospasm (wheezing); shortness of breath; shock; abdominal cramping; or cardiovascular collapse

Precautions to influenza vaccines include the following:

Egg Allergy.

Note: People with a history of egg allergy of any severity **should** receive an influenza vaccine. However, those who have a history of **severe** allergic reaction to egg (i.e., any symptom other than hives) should be vaccinated in a medical setting (including but not necessarily limited to hospitals, clinics, health departments, and physician offices), under the supervision of a health care provider who is able to recognize and manage severe allergic conditions.

Personal history of Guillain-Barré Syndrome

Other: Please describe:

I certify that my patient has the above contraindication or precaution and I suggest a medical exemption from the influenza vaccination.

Provider Name

Provider Signature

Date