NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
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Division of Public Health

MEMORANDUM

TO: North Carolina Immunization Program (NCIP) Participants

FROM: Wendy Holmes, R.N., Head/ WH
Immunization Branch

DATE: August 3, 2020

SUBJECT: Revised Medical Exemption Statement and Physician's Request for Medical Exemption Forms

The purpose of this memo is to notify NCIP providers of important revisions to the Medical Exemption Statement Form (DHHS-3987) and the Physician's Request for Medical Exemption Form (DHHS-3995). Providers should begin using the revised forms effective August 3, 2020. Please discard of or recycle any previous editions of these forms and only use the updated versions with an "08/20" revision date.

The revised forms are included for your convenience and use. Additional copies may be downloaded from the Immunization Branch web site at: https://www.immunize.nc.gov/schools/ncexemptions.htm .

Providers who have questions about the forms should contact the Immunization Branch Nurse Call Line at 919-707-5575.

Thank you for all you do to protect the health of North Carolinians.

Attachments (2): Medical Exemption Statement Form (DHHS-3987); Physician's Request for Medical Exemption Form (DHHS-3995)

cc: SMT, Jason Swartz, Ann Nichols, IB Staff, Gregg Griggs, Frank Skwara, Vaccine Manufacturers, Desiree Elekwa-Izuakor, Mark Benton, Elizabeth Hudgins, Terri Pennington

North Carolina Department of Health and Human Services
Women's and Children's Health Section ▪ Immunization Branch

NC MEDICAL EXEMPTION STATEMENT FORM DHHS 3987

Purpose: To provide physicians licensed to practice medicine in North Carolina, a mechanism to certify, pursuant to G.S. 130A-156, a medical exemption to a required immunization(s) due to a contraindication adopted by the NC Commission for Public Health. As set out in 10A NCAC 41A .0404, the NC Commission for Public Health has adopted the contraindications that are recommended by the Advisory Committee on Immunization Practices (ACIP). These contraindications are listed on this form. This form does not need to be submitted for approval to the State Health Director and may be accepted by agencies that require proof of immunizations. For medical exemptions NOT listed in the table below, submit the Physician's Request for Medical Exemption form (DHHS 3995) to the State Health Director for approval, available at https://www.immunize.nc.gov/schools/ncexemptions.htm

Instructions:

1. Complete and sign the form.
2. **Attach a copy of the most current immunization record.**
3. Retain a copy for the patient's medical record.
4. Return the original to the person requesting this form.

Name of Patient _____DOB _____

Name of Parent/Guardian _____ Primary Phone ( ) _____

Home Address (Patient/Parent) _____County_____

Name of Child Care/School/College/University _____

A **contraindication** is a condition in a recipient that increases the risk for a serious adverse reaction. A vaccine should not be administered when a contraindication is present. Medical contraindications for immunizations are described in the most recent recommendations by the ACIP, available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html

Vaccine	Check all contraindications that apply to this patient below:
☐ **Diphtheria, tetanus, pertussis (DTaP)** ☐ **Tetanus, diphtheria, pertussis (Tdap)** ☐ **Tetanus, diphtheria (DT, Td)**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ For pertussis-containing vaccines: encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of a previous dose of DTaP or DTP (for DTaP); or of previous dose of DTaP, DTP, or Tdap (for Tdap)
☐ **Measles, mumps, rubella (MMR)**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Severe immunodeficiency (e.g., hematologic and solid tumors, chemotherapy, congenital immunodeficiency or long-term immunosuppressive therapy), or persons with human immunodeficiency virus [HIV] infection who are severely immunocompromised ☐ Family history of congenital or hereditary immunodeficiency in first-degree relatives (e.g., parents and siblings), unless the immune competence of the potential vaccine recipient has been substantiated clinically or verified by a laboratory test ☐ Pregnancy
☐ **Varicella (Var)**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. ☐ Severe immunodeficiency (e.g., hematologic and solid tumors, chemotherapy, congenital immunodeficiency or long-term immunosuppressive therapy), or persons with HIV infection who are severely immunocompromised ☐ Family history of congenital or hereditary immunodeficiency in first degree relatives (e.g., parents and siblings), unless the immune competence of the potential vaccine recipient has been substantiated clinically or verified by a laboratory test ☐ Pregnancy

☐ **Inactivated Polio Virus (IPV)**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
☐ **Hepatitis B (Hep B)**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Hypersensitivity to yeast
☐ ***Haemophilus influenza* type B (HiB)**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Age younger than 6 weeks
☐ **Pneumococcal Conjugate (PCV13)**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose of PCV13 or any diphtheria-toxoid–containing vaccine or to a component of a vaccine (PCV13 or any diphtheria-toxoid–containing vaccine), including yeast
☐ **Meningococcal Conjugate (MenACWY)**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component, including yeast

A **physician (M.D. or D.O) licensed to practice medicine in North Carolina** must complete and sign this form.

Date exemption ends or the length of time the exemption will apply for the individual: _____

N.C. Physician's Name (please print) _____ Phone _____

Address _____

N.C. Physician's Signature _____ Date _____

For questions, please contact the North Carolina Immunization Branch Nurse On-Call at (919) 707-5575.
Additional copies of this form can be accessed at: https://www.immunize.nc.gov/schools/ncexemptions.htm

North Carolina Department of Health and Human Services
Women's and Children's Health Section ▪ Immunization Branch

NC PHYSICIAN'S REQUEST FOR MEDICAL EXEMPTION FORM DHHS 3995

Purpose: To provide physicians licensed to practice medicine in North Carolina with a mechanism to request a medical exemption to a required immunization(s), pursuant to G.S. 130A-156, for a contraindication not adopted by the NC Commission for Public Health under 10A NCAC 41A .0404 and, therefore, not included on the NC Medical Exemption Statement Form DHHS 3987. Physicians shall state the specific vaccine(s) the individual should not receive, the basis of the request, and the length of time the requested exemption will apply for the individual. This request is subject to review by the State Health Director. The State Health Director may grant or deny a medical exemption to the requested vaccine(s). Additional copies of this form and the NC Medical Exemption Statement Form DHHS 3987 can be accessed at: https://www.immunize.nc.gov/schools/ncexemptions.htm

INSTRUCTIONS

1. Complete and sign the form.
2. Provide documentation necessary to support the request (clinic notes, labs, etc.).
3. **Attach a copy of the most current immunization record.**
4. Retain a copy for the patient's file.
5. Provide a copy to the person requesting the medical exemption.
6. Send the completed form, supporting documentation and the current immunization record to:

NC Department of Health and Human Services
Division of Public Health
Immunization Branch
1917 Mail Service Center
Raleigh, NC 27699-1917

Name of Patient _____DOB _____

Name of Parent/Guardian _____ Primary Phone ( ) _____

Home Address (Patient/Parent) _____County_____

Name of Child Care/School/College/University _____

Please mark the vaccine(s) that the proposed medical exemption(s) applies to:		
☐ DTaP	☐ MMR	☐ Hepatitis B
☐ Tdap	☐ Varicella	☐ Haemophilus influenza type B (HiB)
☐ DT/Td	☐ IPV	☐ Meningococcal Conjugate (MenACWY)
☐ Pneumococcal Conjugate (PCV13)		

For each vaccine marked above, please describe the contraindication(s) and the proposed length of time that would apply (attach additional pages if necessary): _____

_____

_____

_____

_____

_____

A physician (M.D. or D.O.) licensed to practice medicine in NC must complete and sign this form.

N.C. Physician's Name (please print) _____ Phone _____

Mailing Address _____

N.C. Physician's Signature _____ Date _____

For questions, please contact the North Carolina Immunization Branch Nurse Call Line at (919) 707-5575.