



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
CHILDREN'S ADMINISTRATION  
Specific Office

### Medical Exemption for Influenza Vaccination

Washington Administrative Code (WAC) 388-148-1320 (6) requires that all persons living in foster homes be immunized against influenza in order to protect vulnerable children in care under age two (2) years of age from contracting influenza. The department will provide exemption for persons unable to receive the influenza vaccine because of a valid medical reason and there is no other form of the vaccine that would not cause severe medical consequences.

Valid medical contraindications include history of (1) Guillain-Barre Syndrome within 6 weeks of receiving influenza vaccine and (2) severe allergic reaction (i.e., anaphylaxis) to any vaccine component, including egg protein, or after a previous dose of any influenza vaccine.

There is now available an influenza vaccine for persons 18-49 years of age that does not contain egg, a recombinant vaccine (RIV3).

**To be completed by the person seeking the exemption:**

\_\_\_\_\_, Date of Birth \_\_\_\_\_, is an individual requiring an influenza vaccination in order to live or work in a licensed foster home or group care facility. This person meets the following criteria and must be exempted from this requirement.

I attest that I (or the child listed above) am unable to receive the influenza vaccine because:

- I developed Guillain-Barre Syndrome within six weeks of receiving the influenza vaccine.
- I am severely allergic to eggs.
- I developed a severe allergic reaction after a previous dose of the influenza vaccine and there are no alternative types of the vaccine that would not cause me severe medical consequences.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature (person seeking exemption or legal guardian of the person above.)      \_\_\_\_\_  
Date

**To be completed by the health care provider:**

**A provider may grant a medical exemption only if there is a medical contraindication to the vaccine.**

- I am the health care provider for \_\_\_\_\_.
- I am a qualified MD, ND, DO, ARNP or PA licensed under Title 18 RCW.
- I have counseled him \ her as to the importance of influenza vaccine in order to protect vulnerable children who live in the home.
- He \ she does not qualify for the recombinant vaccine (RIV3) which does not contain egg protein.
- I have reviewed his \ her medical history and attest that the information stated in this form is complete and correct.

Please check one box:

- This medical exemption is needed permanently.
- This medical exemption is needed until \_\_\_\_\_.  
Date

\_\_\_\_\_  
Signature of Licensed Health Care Provider      \_\_\_\_\_  
Date