**INFLUENZA VACCINATION**
**REQUEST FOR MEDICAL EXEMPTION**
**2014-2015 FLU SEASON**

Advocate Health Care
Inspiring medicine. Changing lives.

**Credentialed providers please complete the shaded areas**

| NAME | | DOB | / / |
|---|---|---|---|
| SITE | ❑ ACL ❑ Adv at Home ❑ AMG<br>❑ BROM ❑ CMC ❑ COND<br>❑ Dreyer ❑ EUR ❑ GSAM<br>❑ GSHP ❑ IMMC ❑ LGH<br>❑ SHER ❑ SSH ❑ TRIN<br>❑ Other: | LAST 4 DIGITS OF SS# | |
| | | PAYROLL # | |
| | | HOME PHONE # | ( ) - |
| | | WORK PHONE # | ( ) - |
| DEPT | | MANAGER | |

Dear Health Care Provider:

As a patient safety initiative, Advocate Health Care supports a mandatory influenza vaccination program similar to other required vaccinations such as MMR and varicella.

Advocate Health Care administers the Quadravalent, inactivated vaccine which is made with killed virus and is administered through the muscle.

Your patient is requesting to be exempt from this vaccination. Medical exemption is allowed for recognized contraindications. Please complete the area below to request medical exemption for your patient. All exemption requests will be reviewed by an exemption oversight committee to ensure they meet the accepted criteria.

Thank you.

**RECOGNIZED CONTRAINDICATIONS TO INFLUENZA VACCINATION**

*(Please select one)*

**NOTE:**
**THERE IS NOW AN EGG, THIMEROSAL, PRESERVATIVE, ANTIBIOTIC AND LATEX FREE VACCINE AVAILABLE**

Please provide a **detailed** description of the reaction:

❑ Severe, life threatening allergic reaction after a dose of flu vaccine or to a vaccine component. _____
______________________________________________________________________
_____________________________________________________

❑ History of Guillain-Barre Syndrome (GBS)________________________________________
______________________________________________________________________

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

Health Care Provider Name:_______________________ Phone #: ( ) - ________

Provider Address:_______________________________________________

Provider Signature:_______________________ Date: ______/___/________

**ASSOCIATE: RETURN THIS FORM TO YOUR LOCAL EMPLOYEE HEALTH DEPARTMENT, SCAN AND EMAIL TO amg-employeehealth@advocatehealth.com, OR FAX TO (847) 698-4486**
**PHYSICIAN: RETURN THIS FORM TO YOUR LOCAL SITE'S EMPLOYEE HEALTH DEPARTMENT OR MEDICAL STAFF OFFICE**