DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

School Vaccination Medical Exemption Form

The School Vaccination Medical Exemption Form is the official Division of Public Health (DPH) document to be completed by a currently licensed health care provider to exempt a child from childcare or school immunization requirements. The clinician certifies that due to a child's health condition or contraindication, the child may be adversely affected on a temporary or permanent basis by one or more of the required vaccines. The signed medical exemption statement verifying true contraindications/precautions is submitted to and accepted by Delaware schools, childcare programs, and other agencies that require proof of immunization. Temporary exemptions are valid for the school year and must be resubmitted the following year. Permanent exemptions are valid for the duration of enrollment and should be reviewed yearly by school nurses. An updated form may be requested by the school nurse at any time.

Vaccine medical contraindications are determined by the Advisory Committee on Immunization Practices (ACIP). This form alone does not require further approval from the Delaware Division of Public Health. This form should be submitted to the child's school nurse for review.

For exemption of medical conditions not listed on this form, the Secondary School Vaccination Medical Exemption Form must also be submitted. The school nurse will forward both this form and the Secondary form to DPH directly for review and approval.

Parent/Guardian Information and Acknowledgement:

I am aware that in the event that DPH declares an outbreak of a vaccine preventable disease, or if in the estimation of DPH, my child has had, or is at risk of, having an exposure to a vaccine preventable disease, my child shall be temporarily excluded from in-person attendance at the childcare and/or school until the risk period ends, which may be three weeks or longer. My child shall be authorized to return to school once approved by DPH.

Name of Child: _____ DOB: _____

Name of Parent/Guardian: _____

Parent/Guardian Signature: _____ Date: _____

Updated 08/05/2025

PROVIDER USE ONLY:

Vaccine	Check if applicable		Contraindications/Precautions
DTaP TDaP DT/Td	**Permanent**	**Temporary**	**Contraindications**
			• Severe allergic reaction (e.g. anaphylaxis) after a previous dose or to a vaccine component
			• Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) within seven days after receipt of previous dose of DTaP or DTP
			Precautions
			• Progressive neurological disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy: defer until neurological status clarified and stabilized
			• Guillain-Barre syndrome within 6 weeks after a previous dose of a tetanus toxoid-containing vaccine
			• Moderate or severe acute illness with or without fever – **must be reviewed within 30 days**
			• History of arthus-type hypersensitivity reactions after a previous dose of tetanus or diphtheria toxoid-containing vaccine; defer vaccination until at least 10 years has elapsed since the last tetanus-toxoid containing vaccine.
			• Evidence of immunity – **MUST ATTACH LABORATORY RESULTS. Exemption for condition specified in results only. May require vaccination for other conditions in combined vaccines.**
	Permanent	**Temporary**	**Contraindications**
Varicella			• Severe allergic reaction (e.g. anaphylaxis) after a previous dose or to a vaccine component
			• Known severe immunodeficiency (e.g. from hematologic and solid tumors, receipt of chemotherapy, primary or acquired immunodeficiency, long-term immunosuppressive therapy, or patients with HIV infection who are severely immunocompromised).
			• Pregnancy
			• Family history of altered immunocompetence
			Precautions
			• Moderate or severe acute illness with or without fever– **must be reviewed within 30 days**
			• Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product)
			• Receipt of specific antivirals (i.e. acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination; if possible, delay administration of these antiviral drugs for 14 days after vaccination.
			• Use of aspirin or aspirin-containing products
			• **DOCUMENTED** past history of Varicella disease or evidence of immunity – **MUST ATTACH LABORATORY RESULTS**
	Permanent	**Temporary**	**Contraindications**
IVP OVP			• Severe allergic reaction (e.g. anaphylaxis) after a previous dose or to a vaccine component
			Precautions
			• Pregnancy
			• Moderate or severe acute illness with or without fever – **must be reviewed within 30 days**

			• Evidence of immunity – **MUST ATTACH LABORATORY RESULTS**
	Permanent	**Temporary**	**Contraindications**
Hepatitis B			• Severe allergic reaction (e.g. anaphylaxis) after a previous dose or to a vaccine component
			Precautions
			• Moderate or severe acute illness with or without fever – **must be reviewed within 30 days**
	Permanent	**Temporary**	**Contraindications**
MMR			• Severe allergic reaction (e.g. anaphylaxis) after a previous dose or to a vaccine component
			• Pregnancy
			• Known severe immunodeficiency (e.g. hematologic and solid tumors, or severely symptomatic infection)
			• Family history of altered immunocompetence
			Precautions
			• Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product)
			• History of thrombocytopenia or thrombocytopenia purpura
			• Moderate or severe acute illness with or without fever – **must be reviewed within 30 days**
			• Need for tuberculin skin testing or IGRA testing
			• Evidence of immunity – **MUST ATTACH LABORATORY RESULTS. Exemption for condition specified in results only. May require vaccination for other conditions in combined vaccines.**
	Permanent	**Temporary**	**Contraindications**
Meningococcal			• Severe allergic reaction (e.g. anaphylaxis) after a previous dose or to a vaccine component
			Precautions
			Moderate or severe acute illness with or without fever
			• Receipt of specific antivirals (i.e. acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination; if possible, delay administration of these antiviral drugs for 14 days after vaccination.
			• Evidence of immunity – **MUST ATTACH LABORATORY RESULTS**

❑ **CHECK HERE IF SPECIFIC CONTRAINDICATION NOT LISTED. MUST ALSO COMPLETE SECONDARY FORM.**

Provider Information:

Clinician Name (print) _____ Credentials: _____

Address: _____ Phone: _____

Licensing State: _____ License Number: _____

Signature: _____ Date: _____

Reviewed by school nurse: _____ ***Date:*** _____