Mass General Brigham

INFLUENZA VACCINE MEDICAL EXEMPTION REQUEST

First Name:_____ Last Name:_____

Employee ID #:_____ Date of Birth:_____

Mass General Brigham and its affiliates are committed to providing a safe environment. Transmission of influenza can carry a significant risk for patients, co-workers and visitors. Even those workforce members who do not work directly with patients or in the same space as patients may travel to Mass General Brigham facilities and therefore all Mass General Brigham workforce members are required to receive an annual influenza vaccination or have an approved medical exemption.

Your patient has indicated that they have a medical reason or contraindication not to be vaccinated. Please provide documented medical diagnosis and contraindication below.

Please note that the egg-free influenza vaccine formulation is available through Occupational Health at no cost and an egg allergy is no longer considered a medical contraindication.

☐ History of Guillain-Barre syndrome that developed within 6 weeks of receiving vaccine
Date of Diagnosis: _____

☐ Anaphylaxis or severe allergic reaction following a dose of influenza vaccine or known allergy to any component in the influenza vaccine **Date of Reaction/Diagnosis of Allergy**:_____

***** Include the type of reaction, when did the reaction occur and any treatment administered*

_____

_____

☐ Medical Diagnosis, explanation of contraindication, acute illness or pregnancy needing a temporary exemption, and date of anticipated vaccination_____

_____

_____

Provider/Specialty Information: **Date**:_____

Provider Name: _____ **State & License #:**_____

Provider Signature: _____ **NPI #**: _____

Address/City/State/Zip Code: _____

Name of Specialty:_____**Telephone:** _____

Please return this completed form via WorkWell.