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 the NCDHHS website.

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 the CDC website.

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 the NCDHHS website.