University of Pittsburgh School of Nursing
Influenza Vaccine Documentation and
Exemption Request Forms

STUDENT INFORMATION

(ALL FIELDS MUS T BE COMPLETED)

NAME: _____/_____/ _____
(LAST NAME) (FIRST NAME) (Middle Initial)

TELEPHONE: _____ E-MAIL: _____

DATE COMPLETED: _____
(MONTH/DAY/YEAR)

HEATH CARE PROVIDER TO COMPLETE

INFLUENZA VACCINE DATE: _____ Lot Number: _____
(MONTH/DAY/YEAR)

HEALTH CARE PROVIDER SIGNATURE: _____
(A DOCUMENTATION OF VACCINE FORM FROM A HEALTH CARE PROVIDER OR SETTING CAN BE UPLOADED WITH THIS FORM IN LIEU OF A SIGNATURE)

ARE YOU REQUESTING A MEDICAL OR RELIGIOUS EXEMPTION FROM THE INFLUENZA VACCINE REQUIREMENT?

☐ YES (in addition to this page, you must complete, sign and scan Page 2; both pages must be uploaded to Exxat)

☐ NO (complete Page 1 only; scan and upload this page to Exxat)

UPON COMPLETION, THIS FORM MUST BE UPLOADED BY THE STUDENT TO Exxat.

INFLUENZA VACCINE EXEMPTION REQUEST FORM
STUDENT

FIRST NAME/LAST NAME: _____ DATE COMPLETED: _____
(MONTH/DAY/YEAR)

1. Is this request for **MEDICAL** reasons?

☐ YES

IF YES, check the reasons corresponding to the applicable medical contraindication:

☐ Previous severe reaction to influenza vaccine (hives, difficulty breathing, swelling or tongue or lips)
Note: the above does not include mild to moderate local reactions, soreness, itching or swelling at the injection site, and/or feeling ill including an upper respiratory infection or low-grade or moderate fever following a prior dose of the vaccine.

☐ Severe egg allergy (an egg-free vaccine is currently available)
Note: You experienced cardiovascular changes (hypotension), respiratory distress (wheezing), gastrointestinal symptoms (nausea/vomiting), or reactions requiring epinephrine/emergency medical care.

☐ History of Guillain-Barre Syndrome (GBS)

☐ Other; please describe the reaction/contraindication: _____

_____

☐ NO

2. Is this request for **RELIGIOUS** reasons?

☐ YES

IF YES, please indicate the applicable religious organization where influenza vaccine in contraindicated according to your doctrine or religious practice. Please be aware that the religious organization may be contacted for further clarification.

Name of the religious organization: _____

Address of the religious organization: _____

_____

_____

I certify that the above exemption applies to my ability to receive the influenza vaccine. The School of Nursing reserves the right to substantiate any of the above exemptions/contraindications and I agree to comply if asked for any additional supporting documentation. I fully understand that any misrepresentation will result in corrective action up to and including dismissal from the School of Nursing.

I also understand that if I am granted an exemption from receiving the influenza vaccine for medical or religious reasons, I may be required by clinical agencies to wear a mask at all times while in an inpatient, outpatient, or community setting and within 6 feet of a patient during the entire influenza season.

Full Name: _____ Date Completed: _____
By typing my name above, I attest that I completed this form (MONTH/DAY/YEAR)

UPON COMPLETION, THIS FORM MUST BE UPLOADED BY THE STUDENT TO Exxat.