ENVIRONMENTAL HEALTH & SAFETY
UNIVERSITY of WASHINGTON

2017 Influenza Waiver Letter for Providers

Dear Health Sciences Student,

Students in Health Sciences schools/programs are required to be vaccinated against influenza, per the guidelines set forth by the Centers for Disease Control and Prevention (CDC) for health care personnel. Many of the area hospitals and clinics expect students assigned there for clinical/practicum placements to show proof of having received an annual immunization for flu. The only exception is if the student has a medical contraindication that prevents them from receiving the vaccine.

This form allows your provider to document CDC-accepted rationale for medical contraindication. Please have your health care provider (MD, ARNP, PA, DO, or ND only) complete ALL sections.

A new form MUST be submitted annually for flu waiver requests.

Section 1: Student Information

Student Name: ______________________________ DOB: ____/____/_____
Last, First MO DAY YR

School/Program: ______________________________

Section 2: Waiver Rationale

If there is a MEDICAL reason the above named student is unable to receive the 2017-2018 annual flu vaccine, then the authenticating provider (MD, ARNP, PA, DO, or ND) must indicate which one of the two options in this section prevents immunization. ***NOTE: Egg allergy is not a contraindication (but may require supervised administration). Egg-free vaccine is available.***

I have verified that the above named individual has the following medical contraindication for declining flu vaccine this year, per stated CDC guidelines referenced at

https://www.cdc.gov/mmwr/volumes/66/rr/rr6602a1.htm?s_cid=rr6602a1_w#T2_down

(check applicable box):

- ☐ Severe allergic reaction (e.g. anaphylaxis) after a previous dose of flu vaccine or to a vaccine component
- ☐ History of Guillain-Barre Syndrome (GBS) within 6 weeks of previous influenza vaccination; risks of vaccination outweigh benefits at this time

Section 3: Provider Authentication

Required:

Signature: ______________________________(MD, ARNP, PA, DO, ND)

Printed Name: ______________________________

Phone number: ____________________ Date: _____________

FACILITY STAMP

Return this completed form, signed and dated by provider, to HSIP, Box 354400, Seattle, WA 98195-4410. Fax to: 206-616-8434 or Email scanned copy to: myshots@uw.edu
Phone: 206-616-9074 for more information

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