Mississippi Baptist Medical Center

Influenza Vaccination Medical or Religious Exemption Form for Faculty and Students

Faculty/Student Name: _______________________________ Phone #: ________________ Last 4 Digits SS#: ______

School: ____ Semester: ____________________________________

Supervisor/Instructor: _______________________ Instructor Phone #: _________ 6 Digit ID#: ________________

Medical Exemption Request

INFLUENZA

The above named person should not be immunized for influenza for the following medical reasons:

____ History of previous severe allergic reaction and documented allergy testing to indicate an immediate hypersensitivity reaction to the influenza vaccine or a component of the vaccine**. Please attach supporting documentation or medical records**. *ACIP recommends that persons with egg allergy of any severity receive influenza vaccine.

____ History of Guillain-Barré Syndrome after receiving a previous vaccine. **Please attach supporting documentation or medical records**.

____ Other – Please attach a detailed narrative that describes the reason for exemption.

I certify that _____________________________ has the above contraindication and requests a medical exemption from the influenza vaccination.

Physician Signature: ____ Date: __/__/__

Physician Medical License Number: ________________________

Religious Exemption Request

___ Because the required vaccination(s) indicated above conflicts with my sincerely held religious beliefs and practices or membership in a church or religious body, I decline the indicated vaccination(s) at this time.

___ **Please provide a personal statement/written narrative** explaining your religious belief and help us understand how your religious belief conflicts with the vaccination requirement and safety protocol.

Name of Religious Belief, Church, or Body: ____

Signature: ____ Date: __/__/__

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Verification and Accuracy – to be completed by Faculty/Student:

Please read and initial by each of the following and sign at the bottom.

____ I verify that the above information is complete and accurate to the best of my knowledge and I understand that any intentional misrepresentation contained in this request may lead to disciplinary action, up to and including discharge.

____ I also understand that my request for an exemption may not be granted if it is unreasonable or if it creates an undue hardship on my employer.

____ I also understand that failing to receive the Influenza Vaccination, or an approved exemption will result in disciplinary action, up to and including discharge.

____ I also understand that the influenza vaccine is being offered to me at no charge and that I can later receive the influenza vaccination if I change my mind.

Faculty/Student Signature: ____ Date: __/__/__

Please send completed document and any supporting documentation to whomever at MBMC is coordinating your clinical rotation.

FOR HOSPITAL USE ONLY

Date Received: ______________ Initials of Recipient: _______________ Documentation Attached? ________

Exception Granted? YES ____ NO ____ If no, explain why: ____

Faculty Contacted of Decision: (Date/Time) ____

Authorized signature: ____ Date: ____________

Form Last Updated 9-18-17, 9-5-18, 9-5-19, 8-26-20; 8-12-21; 9-10-21, 1-26-22, 8-9-22, 8/10/23