Allegany College of Maryland
Nurse Managed Wellness Clinic

IMMUNIZATION WAIVER FORM

The Centers for Disease Control and Prevention (CDC) and the Healthcare Infection Control Practices Advisory Committee (HICPAC) recommend immunizations for vaccine-preventable diseases for all healthcare personnel. Vaccination to these diseases provides protection for the healthcare worker as well as patients. Clinical agencies require documentation of immunization status for health program students prior to beginning clinical rotations.

I, (Student name) ______________________ understand that due to my status as a healthcare student I may be exposed to vaccine-preventable viruses, blood or other potentially infectious materials and may be at risk of contracting certain diseases. I understand that these diseases could cause not only discomfort but harm to myself and anyone I may encounter, putting my patients at risk of acquiring the disease from me, and affect my ability to participate in a clinical rotation. I understand that if a vaccination is required by a clinical site or by any local/state/federal law or regulation, I cannot participate in a clinical course which will adversely affect my ability to complete the program.

NOTE: Students with disabilities should contact Academic Access & Disability Resources if accommodations are needed for program requirements besides clinical site vaccination requirements.

REQUIRED IMMUNIZATIONS FOR ACM HEALTHCARE PROGRAMS

I have been counseled on the risks associated with acquiring Measles, Mumps, Rubella, and Varicella, as well as the risks and benefits of the immunizations.

I am unable to receive the ____ INFLUENZA ____ MMR ____ Tdap _____ VARICELLA vaccine(s) based on the “Vaccine Recommendations and Guidelines of the ACIP: Contraindications and Precautions” (2019). (Please explain contraindications): ______________________________________

RECOMMENDED (OPTIONAL) FOR ACM HEALTHCARE PROGRAMS

HEPATITIS B VACCINE (3-dose series)-

I have been counseled on the risks associated with acquiring Hepatitis B, a serious disease, as well as the risks and benefits of the 3-dose Hepatitis B immunization series.

_______ I decline this vaccination series

_______ I am unable to receive this vaccine according to “Vaccine Recommendations and Guidelines of the ACIP: Contraindications and Precautions” (2019). (Please explain contraindications)

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COVID-19 VACCINE
I have been counseled on the risks associated with acquiring and transmitting Covid-19, a serious and potentially fatal disease, as well as the risks and benefits of the Covid-19 vaccine.

_____ I decline this vaccination.

_____ I am unable to receive this vaccine (Please explain below)

__________________________________________________________________________________________

Healthcare Provider: ____________________________________________ Date: ________________
Address: ______________________________________________________ Phone:_______________
Student Name (PRINT): ____________________________ Program: ________________
Student Signature: ____________________________ Date: ________________

ADDITIONAL WAIVER INFORMATION:
As a public institution, Allegany College of Maryland does not discriminate on the basis of religious beliefs.

I have read all the information and had an opportunity to ask any questions about these vaccines. I have no contraindications/precautions as detailed above. However, I have the following bona fide religious beliefs and practices that prevent my being immunized:

__________________________________________________________________________________________

In support of my bona fide religious beliefs and practices, I provide supporting information/documentation (attached or submitted via email).

As noted above, I understand that the College, this program, and the Nurse Managed Wellness Clinic cannot change the requirements for clinical sites, so if I decline to be vaccinated as required by a clinical site or by any local/state/federal law or regulation without an authorized and accepted waiver I limit my learning opportunities that may adversely affect my ability to complete my program of study at ACM.

Student Name (PRINT): ____________________________ Program: ________________
Student Signature: ____________________________ Date: ________________
# Contraindications and Precautions to Commonly Used Vaccines

This table is adapted from the reference “Vaccine Recommendations and Guidelines of the ACIP: Contraindications and Precautions”. (2019) [https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html](https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Contraindications</th>
<th>Precautions</th>
</tr>
</thead>
</table>
| DT, Td (diphtheria and tetanus toxoids, tetanus and diphtheria toxoids) | Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component | GBS <6 weeks after previous dose of tetanus-toxoid–containing vaccine  
History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid—containing or tetanus-toxoid–containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid-containing vaccine  
Moderate or severe acute illness with or without fever |
| Hepatitis B | Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component  
Hypersensitivity to yeast | Moderate or severe acute illness with or without fever |
| IIV (inactivated influenza vaccine) | Severe allergic reaction (e.g., anaphylaxis) after previous dose of influenza vaccine or to vaccine component. | GBS <6 weeks after a previous dose of influenza vaccine  
Moderate or severe acute illness with or without fever  
Egg allergy other than hives, e.g., angioedema, respiratory distress, lightheadedness, recurrent emesis; or required epinephrine or another emergency medical intervention (IIV may be administered in an inpatient or outpatient medical setting and under the supervision of a health care provider who is able to recognize and manage severe allergic conditions). |
| LAIV (live, attenuated influenza vaccine) | Severe allergic reaction (e.g., anaphylaxis) after a vaccine component, including egg protein  
Concomitant use of aspirin or aspirin-containing medication in children and adolescents  
LAIV4 should not be administered to persons who have taken influenza antiviral medications within the previous 48 hours | GBS <6 weeks after a previous dose of influenza vaccine  
Asthma in persons aged 5 years old or older  
Medical conditions which might predispose to higher risk of complications attributable to influenza  
Moderate of severe acute illness with or without fever |
| MMR (measles, mumps, and rubella) | Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component  
Pregnancy  
Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or | Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product)  
History of thrombocytopenia or thrombocytopenic purpura  
Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing |
## Allegany College of Maryland
### Nurse Managed Wellness Clinic

<table>
<thead>
<tr>
<th>Condition</th>
<th>Indications/Contraindications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>patients with HIV infection who are severely immunocompromised</strong></td>
<td>Moderate or severe acute illness with or without fever</td>
</tr>
<tr>
<td>Family history of altered immunocompetence</td>
<td></td>
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<tr>
<td><strong>Tdap</strong> (tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis)</td>
<td>Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component</td>
</tr>
<tr>
<td></td>
<td>Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures), not attributable to another identifiable cause, within 7 days of administration of previous dose of DTP, DTaP, or Tdap</td>
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<tr>
<td></td>
<td>GBS &lt;6 weeks after a previous dose of tetanus-toxoid–containing vaccine</td>
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<tr>
<td></td>
<td>Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized</td>
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<td></td>
<td>History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid—containing or tetanus-toxoid–containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid–containing vaccine</td>
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<tr>
<td></td>
<td>Moderate or severe acute illness with or without fever</td>
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<tr>
<td><strong>Varicella</strong></td>
<td>Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component</td>
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<td></td>
<td>Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised)</td>
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<td>Pregnancy</td>
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<td>Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product)</td>
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<td>Moderate or severe acute illness with or without fever</td>
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<tr>
<td></td>
<td>Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination)</td>
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