

Medical Exemption Statement

Physician: Please mark the contraindications/precautions that apply to this patient, then sign and date the back of the form. The signed Medical Exemption Statement verifying true contraindications/precautions is submitted to and accepted by schools, childcare facilities, and other agencies that require proof of immunization. For medical exemptions for conditions not listed below, please note the vaccine(s) that is contraindicated and a description of the medical condition in the space provided at the end of the form. The State Medical Officer may request to review medical exemptions.

Attach a copy of the most current immunization record

Name of patient _____ DOB _____

Name of parent/guardian _____

Address (patient/parent) _____

School/child care facility _____

For Official Use Only:

Check if reviewed by public health Name/credentials of reviewer: _____ Date of review: _____

Medical contraindications for immunizations are determined by the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP), U.S. Department of Health and Human Services, published in the Centers for Disease Control and Prevention's publication, the Morbidity and Mortality Weekly Report.

A **contraindication** is a condition in a recipient that increases the risk for a serious adverse reaction. A vaccine will not be administered when a contraindication exists.

A **precaution** is a condition in a recipient that might increase the risk for a serious adverse reaction or that might compromise the ability of the vaccine to produce immunity. Under normal conditions, vaccinations should be deferred when a precaution is present.

Contraindications and Precautions

Vaccine	
Hepatitis B (not required for school attendance)	<p>Contraindications</p> <input type="checkbox"/> Serious allergic reaction (e.g., anaphylaxis) after a previous vaccine dose or vaccine component
	<p>Precautions</p> <input type="checkbox"/> Moderate or severe acute illness with or without fever
DTaP DT, Td Tdap	<p>Contraindications</p> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Encephalopathy within 7 days after receiving previous dose of DTP or DTaP
	<p>Precautions</p> <input type="checkbox"/> Progressive neurologic disorder, including infantile spasms, uncontrolled <input type="checkbox"/> epilepsy, progressive encephalopathy; defer DTaP until neurological status has clarified and stabilized <input type="checkbox"/> Fever $\geq 40.5^{\circ}\text{C}$ (105°F) within 48 hours after vaccination with previous dose of DTP or DTaP <input type="checkbox"/> Guillain-Barre' syndrome ≤ 6 weeks after a previous dose of tetanus toxoid-containing vaccine <input type="checkbox"/> Seizure ≤ 3 days after vaccination with previous dose of DTP or DTaP <input type="checkbox"/> Persistent, inconsolable crying lasting ≥ 3 hours within 48 hours after vaccination with previous dose of DTP/ DTaP <input type="checkbox"/> History of arthus-type hypersensitivity reactions after a previous dose of tetanus toxoid- containing vaccine <input type="checkbox"/> Moderate or severe acute illness with or without fever
IPV	<p>Contraindications</p> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
	<p>Precautions</p> <input type="checkbox"/> Pregnancy <input type="checkbox"/> Moderate or severe acute illness with or without fever

Name of Patient: _____

Date Exemption Ends: ____/____/____

Vaccine	
PCV (not required for school attendance)	<p>Contraindications</p> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose (of PCV7, PCV13, or any diphtheria toxoid--contain vaccine) or to a component of a vaccine (PCV7, PCV13, or any diphtheria toxoid-containing vaccine)
Hib	<p>Contraindications</p> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Age <6 weeks
MMR	<p>Contraindications</p> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Known severe immunodeficiency (e.g., hematologic and solid tumors, chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy, or patients with HIV infection who are severely immunocompromised) <input type="checkbox"/> Pregnancy
Varicella	<p>Contraindications</p> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Known severe immunodeficiency (e.g., hematologic and solid tumors, chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy, or patients with HIV infection who are severely immunocompromised) <input type="checkbox"/> Pregnancy
<p>Precautions</p> <input type="checkbox"/> Moderate or severe acute illness with or without fever	
<p>Contraindications</p> <input type="checkbox"/> Recent (<11 months) receipt of antibody-containing blood product (specific interval depends on the product) <input type="checkbox"/> History of thrombocytopenia or thrombocytopenic purpura <input type="checkbox"/> Need for tuberculin skin testing <input type="checkbox"/> Moderate or severe acute illness with or without fever	
<p>For medical conditions not listed, please note the vaccine(s) that is contraindicated and a description of the condition:</p>	
<p>_____</p>	
<p>_____</p>	

A physician (M.D. or D.O) licensed to practice medicine must complete and sign this form.

Date exemption ends: _____

Physician's Name (please print) _____ Phone _____

Address _____

Physician's Signature _____ Date _____

<p>Instructions:</p> <ol style="list-style-type: none"> 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.

For questions call (406) 444-5580

Additional copies of this form can be accessed at: <http://www.dphhs.mt.gov/publichealth/immunization/>

Montana Code Annotated

20-5-403: MT School Immunization Requirements

52-2-735: Child Care Health Protection - Certification

Administrative Rules of Montana

37.114.701-721: Immunization of K-12, Preschool, and Post-

secondary schools 37.95.140: Daycare Center Immunizations, Group

Daycare Homes, Family Day Care Homes



AFFIDAVIT OF EXEMPTION ON RELIGIOUS GROUNDS FROM MONTANA SCHOOL IMMUNIZATION LAW AND RULES

Student's Full Name _____

Birth Date _____

Age _____

Sex _____

School: _____

If student is under 18, name of parent, guardian, or other person responsible for student's care and custody: _____

Street address and city: _____

Telephone: _____

I, the undersigned, swear or affirm that immunization against

Diphtheria, Pertussis, Tetanus (DTaP, DT, Tdap)

Polio

Measles, Mumps and Rubella (MMR)

Varicella (chickenpox)

Haemophilus Influenzae Type b (Hib)

is contrary to my religious tenets and practices.

I also understand that:

- (1) I am subject to the penalty for false swearing if I falsely claim a religious exemption for the above-named student [i.e. a fine of up to \$500, up to 6 months in jail, or both (Sec. 45-7-202, MCA)];
- (2) In the event of an outbreak of one of the diseases listed above, the above-exempted student may be excluded from school by the local health officer or the Department of Public Health and Human Services until the student is no longer at risk for contracting or transmitting that disease; and
- (3) **A new affidavit of exemption for the above student must be signed, sworn to, and notarized yearly, before the start of the school year and kept together with the State of Montana Certificate of Immunization (HES-101) in the school's records.**

Signature of parent, guardian, or other person
responsible for the above student's care and
custody; or of the student, if 18 or older.

Date

Subscribed and sworn to before me this _____ day of _____, _____.

Signature: Notary Public for the State of Montana

Print Name: Notary Public for the State of Montana

Residing in _____

My commission expires _____