

Medical Exemption Statement

Form HES 101A
Montana Schools



For questions, contact the Montana Department of Immunizations at (406) 444-5580

A prospective student seeking to enroll in a Montana school is not required to receive any immunizations for which they are medically contraindicated. The Medical Exemption Statement, may be completed by a qualifying healthcare provider and utilized as an exemption. In lieu of this form, a written and signed statement from a qualifying healthcare provider will also be accepted under the conditions outlined in ARM 37.114.715.

Pursuant to HB 334 (Ch. 294, L. 2021), a qualifying healthcare provider means a person who: (1) is licensed, certified, or authorized in any U.S. State or Canada to provide health care; (2) is authorized within the person's scope of practice to administer the immunization(s) to which the exemption applies; and (3) has previously provided health care to the student *or* has administered a vaccine to which the student has had an adverse reaction. Once completed, this form should be filed at the student's school along with their most current immunization record.

Student Name: _____ **Parent/Guardian Name:** _____

Student Address: _____ **Student Date of Birth:** _____

Select the vaccine(s) needing medical exemption, then provide a brief description of the contraindication or precaution for each vaccine:

- | | |
|--|--|
| <input type="checkbox"/> DTaP (Diphtheria, Tetanus, and Pertussis) | <input type="checkbox"/> MMR (Measles, Mumps, and Rubella) |
| <input type="checkbox"/> Tdap (Diphtheria, Tetanus, and Pertussis) | <input type="checkbox"/> IPV (Polio) |
| <input type="checkbox"/> Varicella (Chickenpox) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hib (<i>Haemophilus influenzae</i> type b) | |

Contraindication/Precaution:

A complete list of medical contraindications and precautions can be found on the Centers for Disease Control and Prevention's website:

<https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html>

Duration of exemption: _____

Provider's Name (print): _____ **Title:** _____ **Phone:** _____

Address: _____

Provider's Signature: _____ **Date:** _____