3414F2

Affidavit of Exemption on Religious Grounds

Form HES 113
Montana Schools

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

For questions, contact the Montana Department of Immunizations at (406) 444-558(

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, declare under penalty of perjury that immunization against the following is contrary to my religious tenets and practices (check all that apply):

- ☐ *Diphtheria, Pertussis, Tetanus (DTaP, DT, Tdap)*
- ☐ *Measles, Mumps and Rubella (MMR)*
- ☐ *Haemophilus Influenzae type b (Hib)*
- ☐ *Polio*
- ☐ *Varicella (chickenpox)*
- ☐ *Other:* _____

I also understand that:

Pursuant to section 20-5-405, MCA, 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.

_____

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

Seal

_____

Print Name: Notary Public for the State of Montana

Residing in _____

My commission expires _____

3413F1

Medical Exemption Statement

Form HES 101A
Montana Schools

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

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:

- ☐ DTaP (Diphtheria, Tetanus, and Pertussis)
- ☐ Tdap (Diphtheria, Tetanus, and Pertussis)
- ☐ Varicella (Chickenpox)
- ☐ Hib (*Haemophilus influenzae* type b)
- ☐ MMR (Measles, Mumps, and Rubella)
- ☐ IPV (Polio)
- ☐ Other: _____

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:** _____

Montana Code Annotated
20-5-403: MT School Immunization Requirements, Immunization Records
20-5-405: MT School Immunization Requirements, Exemptions

Administrative Rules of Montana
37.114.701-721: Immunization of K-12, Preschool, and Post-Secondary Schools