Montana Department of Public Health and Human Services (DPHHS)
Communicable Disease Control and Prevention Bureau • Immunization Program

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)	**Contraindications** ☐ Serious allergic reaction (e.g., anaphylaxis) after a previous vaccine dose or vaccine component **Precautions** ☐ Moderate or severe acute illness with or without fever
DTaP **DT, Td** **Tdap**	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Encephalopathy within 7 days after receiving previous dose of DTP or DTaP **Precautions** ☐ Progressive neurologic disorder, including infantile spasms, uncontrolled ☐ epilepsy, progressive encephalopathy; defer DTaP until neurological status has clarified and stabilized ☐ Fever ≥40.5°C (105°F) within 48 hours after vaccination with previous dose of DTP or DTaP ☐ Guillain-Barre′ syndrome ≤6 weeks after a previous dose of tetanus toxoid-containing vaccine ☐ Seizure ≤3 days after vaccination with previous dose of DTP or DTaP ☐ Persistent, inconsolable crying lasting ≥3 hours within 48 hours after vaccination with previous ☐ dose of DTP/ DTaP ☐ History of arthus-type hypersensitivity reactions after a previous dose of tetanus toxoid- containing vaccine ☐ Moderate or severe acute illness with or without fever
IPV	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component **Precautions** ☐ Pregnancy ☐ Moderate or severe acute illness with or without fever

Name of Patient: _____ **Date Exemption Ends:**___/___/___

Vaccine	
PCV (not required for school attendance)	**Contraindications** ☐ 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) **Precautions** ☐ Moderate or severe acute illness with or without fever
Hib	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Age <6 weeks **Precautions** ☐ Moderate or severe acute illness with or without fever
MMR	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ 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) ☐ Pregnancy **Precautions** ☐ Recent (<11 months) receipt of antibody-containing blood product (specific interval depends on the product) ☐ History of thrombocytopenia or thrombocytopenic purpura ☐ Need for tuberculin skin testing ☐ Moderate or severe acute illness with or without fever
Varicella	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ 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) ☐ Pregnancy **Precautions** ☐ Recent (<11 months) receipt of antibody-containing blood products (interval depends on product) ☐ Moderate or severe acute illness with or without fever
For medical conditions not listed, please note the vaccine(s) that is contraindicated and a description of the condition:	

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 _____

Instructions:

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