Vaccines Required for School Attendance, Preschool -12th Grade

VACCINE	PRESCHOOL[1]	KINDERGARTEN - 12TH GRADE
Haemophilus influenza Type B (Hib)	**1 dose** (given on or after the 1st birthday, unless child is older than 59 months)[2]	None Needed
Diphtheria, Tetanus, and Pertussis (DTaP, Tdap)	**4 doses**	**4 doses** (one dose must be given on or after 4th birthday)[3,4] **Plus** **1 dose of Tdap** (prior to entering 7th grade)[6]
Polio (IPV or OPV)	**3 doses**	**3 doses** (one dose must be given on or after 4th birthday)[3]
Measles, Mumps, and Rubella (MMR)	**1 dose** (dose must be given on or after 1st birthday)	**2 doses** (first dose must be given on or after 1st birthday, and spacing between doses is 4 weeks)
Varicella "chickenpox" (Var)	**1 dose** (dose must be given on or after 1st birthday)[6]	**2 doses** (first dose must be given on or after 1st birthday, spacing between doses is 12 weeks for children under 13 years, and 4 weeks for those older than 13 years)[5,6]

[1]Per MCA 20-5-402, a preschool is defined as a facility that provides, on a regular basis and as its primary purpose, educational instruction designed for children 5 years of age or younger and that: (a) serves no child under 5 years of age for more than 3 hours a day; and (b) serves no child 5 years of age for more than 6 hours a day.

[2]Hib vaccine is not recommended for children older than 59 months.

[3]When following the ACIP schedule, children will have at least 5 doses of DTaP and 4 doses of polio vaccine.

[4]A pupil 7 years or older who has not completed the DTaP requirement must receive additional doses of Tdap vaccine or Td vaccine to become current in accordance with the Advisory Committee on Immunization Practice (ACIP) recommendations per ARM 37.114.705.

[5]While it is not recommended, if a child younger than 13 years receives their second dose of varicella at an interval of 4 weeks or longer, the dose does **not** need to be repeated.

[6]As of October 1, 2015 pupils are required to have varicella vaccine and all pupils 7th-12th grade must have a Tdap vaccine.

Note: A four-day grace period may apply, as appropriate, per the ACIP recommendations.

September 2018

STATE OF MONTANA— CHILD CARE FACILITY/SCHOOL CERTIFICATE OF IMMUNIZATION

Complete immunization requirements and penalties for those who fail to meet the requirements are referenced in Section V. This form is required for ALL persons attending school or child care. See the reverse side for information about EXEMPTIONS and INSTRUCTIONS.

SECTION I *PLEASE PRINT CLEARLY*

Child/Student's Name	Birth Date	Sex	Primary Provider	
Name of Parent/Guardian	Address		City	Telephone Home Work

SECTION II IMMUNIZATION HISTORY

Valid only when filled out by School, Child Care or Medical Personnel (NOT to be filled out by the parent).

Required Vaccines (CC= Child Care Requirement; SR=School Requirement)	Month, Day & Year of Each Dose 1	2	3	4	5
Diphtheria/Tetanus/Pertussis (DTaP)					
Booster Dose Tdap required prior to 7th grade entry					
Haemophilus Influenzae Type B (Hib) (Only children less than 5 years)					
Measles/Mumps/Rubella (MMR) or					
Measles vaccine only					
Mumps vaccine only					
Rubella vaccine only					
Polio (IPV or OPV)					
Varicella (Chickenpox) [VZV or VAR] Check here if child has documentation of disease					
Hepatitis B					
Pneumococcal Conjugate vaccine (PCV13)					

ACIP* Recommended Vaccines *Advisory Committee on Immunization Practices, U.S. Centers for Disease Control and Prevention	Month, Day & Year of Each Dose 1	2	3	4	5
Hepatitis A					
Human Papillomavirus (HPV) - for adolescents					
Influenza- recommended annually for all over 6 mos.					
Meningococcal Conjugate Vaccine (MCV4) (Ages 11-12 & later)					
Rotavirus					

NOT A COMPLETE IMMUNIZATION RECORD- CONTACT YOUR PROVIDER OR PUBLIC HEALTH AGENCY FOR MORE INFORMATION

If filled out by health department or health care provider:

To the best of my knowledge, this child has received the above immunizations.

Signed: _____
(Health Department/Health Care Provider) Date

Signed: _____
(Health Department/Health Care Provider) Date

Signed: _____
(Health Department/Health Care Provider) Date

Signed: _____
(Health Department/Health Care Provider) Date

If filled out by school or child care personnel:

I CERTIFY this information has been transferred from supporting documentation as stated in the Administrative Rules of Montana:

Signed: _____
(School or Child Care Official and title) *Date*

Signed: _____
(School or Child Care Official and title) *Date*

Signed: _____
(School or Child Care Official and Title) *Date*

Signed: _____
(School or Child Care Official and Title) *Date*

SECTION III INSTRUCTIONS

Health Department or Physician

1. For medical exemption purposes, a physician is a person licensed to practice medicine in any jurisdiction of the U.S. or Canada. This does not include chiropractic or naturopathic doctors, nurse practitioners or physician assistants.
2. In Section II, please include vaccine doses with month, day and year for each administered dose. Immunization dates, as specified in the administrative rules, are necessary. Please sign and date the form.
3. **If the child is completing a vaccine series,** a Conditional Attendance form can be used. The physician or health department will determine the date of each dose to be administered and put the schedule on the Conditional Attendance form. Please sign the Conditional Attendance form, and return to the school or child care facility.
4. Immunization forms can be obtained directly from the local health department or the Montana Immunization Program at immmunization.mt.gov.

School and Child Care Official

1. **Prior to attending**, all students and child care facility attendees must have either **a)** the required immunizations **and documentation** or **b)** have completed the appropriate exemption or conditional attendance documentation. This includes transfer students.
2. **Documentation** must meet the criteria of the Administrative Rules of Montana. This is **limited** to other school health records and certain documents from health departments and physicians.
3. **Transferring information from supporting documentation to this form** must be done by a school or child care official. The school or child care official must then sign and date the form (Section II) and attach the supporting documentation.
4. **Conditional Attendance** form, once completed and attached to this document, allows attendance so long as immunization continues as scheduled.
5. **School Transfer Students.**

There is no transfer period allowed. Transfer students must provide adequate documentation of immunization **PRIOR** to attending school.

a) **Transferring In:** Students who transfer into Montana from out of state must have their immunization information recorded on this form (*See number 2 above regarding acceptable documentation.)* Students must meet Montana immunization requirements.

b) **Transferring Out:** If students transfer out of your school, a **copy** of this record should be maintained for one year following the transfer. The Montana law requires schools to forward the original Certificate of Immunization to the school to which students transfer.

c) **Homeless Students:** All homeless students must be immediately enrolled in a Montana school to ensure compliance with the McKinney-Vento Act. Students should be assigned a liaison who can assist them in obtaining either appropriate documentation of immunization or in obtaining the required immunizations.

Parent

1. Montana law requires immunization information be recorded on this document for persons to attend Montana schools, preschools and child care facilities.
2. **ONLY school, child care and health officials can complete this form.** School and child care officials need documentation from physicians or health departments as described by the Administrative Rules of Montana (*examples: A completed Montana Certificate of Immunization; A signed Immunization record card).* **It is the parent's responsibility to provide these documents to the school or child care facility.**
3. **Religious exemption and conditional attendance** may be used in accordance with the Immunization Law and Administrative rules. The Religious Exemption may be used in school settings and must be renewed annually. Religious exemption for child care only applies to Haemophilus influenzae type b (Hib), and must be renewed annually.
4. Montana law prohibits children from attending any Montana school or child care facility **prior** to meeting immunization requirements.
5. If your child transfers to another Montana school, a copy of this completed form will allow your child to enter that school. However, the original Certificate of Immunization must be provided to the new school within 30 days of transfer in order for the child to attend.

SECTION IV EXEMPTIONS

Please refer to the form HES101A at
immunization.mt.gov

SECTION V LEGAL REFERENCES

Montana Codes Annotated
20-5-101 - 410: Montana Immunization Law
52-2-735: Day Care Certification

Administrative Rules of Montana
37.114.701-721: Immunization of K-12, Preschool and Post secondary Schools
37.95.140: Day Care Center Immunizations
Group Day Care Homes – Health
Family Day Care Homes – Health

If you have any questions about: 1) the use of this form; 2) obtaining copies of immunization forms, laws, or rules; or 3) whether or not a person meets attendance requirements, please contact your local health department or the Montana Immunization Program, DPHHS, Cogswell Building, Helena, MT 59620. Phone (406)444-5580.

www.immunization.mt.gov

FORM No. IZ HES101 (Revised 07/2015)

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

MONTANA DPHHS

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 _____, _____.

Seal

_____

Signature: Notary Public for the State of Montana

_____

Print Name: Notary Public for the State of Montana

Residing in _____

My commission expires _____

MONTANA DPHHS