

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

Name of Patient: \_\_\_\_\_

Date Exemption Ends: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

