



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

This After School Packet is for the 2024-25 school year only.

Please download the 2023-24 packet if you are enrolling your child in the current school year. Make sure you are submitting the application for the correct school year.



REQUIRED
Incomplete applications will not be considered

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LICENSED PROGRAM

APPLICATION HELPFUL HINTS

GREATER MISSOULA FAMILY YMCA

Welcome to the Missoula YMCA Licensed Child Care Programs! Refer to the sheet below to help as you fill out your application. Please note that all **REQUIRED** forms must be fully completed and be submitted together. Incomplete packets will not be accepted.

- Contract: REQUIRED**
 - Includes all information needed by the YMCA to complete registration for our program.
 - Includes information important for families to understand regarding program billing, policies, and procedures.

- Payment Authorization: REQUIRED**
 - Includes billing information. Regardless of whether families are paying the full bill or a copay, a billing method is required for scheduled payments.

- Best Beginnings Scholarship: ONLY REQUIRED FOR FAMILIES USING BEST BEGINNINGS SCHOLARSHIP**
 - Formal acknowledgment of the family's responsibilities regarding billing and Best Beginnings copayments.

- Multimedia Waiver: OPTIONAL**
 - The YMCA utilizes local photos and videos in most of our marketing. This waiver gives consent to allow the YMCA to feature your child in our marketing materials in the future.

- Inherent Risk Waiver: REQUIRED**
 - Standard legal waiver required to participate in any YMCA program or membership.

- CACFP Income Eligibility Form: REQUIRED**
 - To participate in the state's Child and Adult Care Food Program, we are required to maintain and submit records of income eligibility for all participants in licensed programming.
 - Should you prefer NOT to disclose this information, the form is still required. A signature and date on Part 7 on the reverse side of the form allows you to opt out of sharing information.

Continues on reverse side.



REQUIRED

- Emergency Contact and Parental Consent: REQUIRED** **Incomplete applications will not be considered**
 - As a state licensed program we are required to maintain records annually. The state mandates signatures from the current year on all paperwork.
 - Watch for the easy to miss signature and date line on the bottom of the back page.

- Over the Counter Medication Authorization: REQUIRED**
 - As a state licensed program we are required to maintain records annually. The state mandates signatures from the current year on all paperwork.

- Certificate of Immunizations: REQUIRED**
 - Included immunization form must be completed and signed by a health department representative, a health care professional, school nurse, or our child care personnel.
 - If completed and signed by our child care personnel, supporting documentation must be included (Immunization Records, MyChart, etc.).

YMCA After School is a state-licensed child care program.

This entire packet must be completed and returned. Incomplete packets will not be considered.



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2024-25 AFTER SCHOOL CONTRACT

GREATER MISSOULA FAMILY YMCA

Application Date: ____/____/____ Requested Start Date: ____/____/____

Child's Name: _____ Gender: _____
Last First M.I.

School: _____ Grade: _____ Date of Birth: ____/____/____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Email Address: _____

For transportation safety, is your child over 60 lbs? Y / N

Any special needs, dietary restrictions, etc.: _____

Emergency Contact Information:

Guardian's Name: _____

Guardian's Name: _____

Relationship: _____

Relationship: _____

Primary Phone: _____

Primary Phone: _____

Work Phone: _____

Work Phone: _____

Custody of child is with: _____

After School Rates:

After school tuition is billed monthly, and rates are based on a daily rate of \$25/day. All registrations require a minimum of 2 days/week. Sign up for more than 2 days/week to receive our multi-day discount to your total monthly bill. (Multi-day discounts reflected below.) Please check which days your child will attend. In order to provide the safest childcare, families must commit to the same After School days each week. Priority placement will be given to families attending full-time.

	M	T	W	Th	F
5 Days (\$374/mo)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Days (\$324/mo)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Days (\$274/mo)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Days (\$225/mo)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Program enrollment is done in monthly cycles. Refunds and credits will not be issued for single-day absences. August, December, March, and June have reduced monthly rates due to extended out-of-school time. All participants must set up an autodraft. A one-time, non-refundable \$55 supply fee (\$75 for families enrolling 2+ children) is required.

After School Contract (continued)

Please read the following statements and **initial**, indicating that you understand and agree to comply.

_____ I understand that there is a supply fee of \$55 (\$75 for families enrolling 2+ children) that is due upon submission of application/contract. I understand that this fee is non-refundable.

_____ I hereby give my consent for my child to participate in water activities.

_____ I hereby give my consent for my child to be transported by Greater Missoula Family YMCA staff to or from school.

_____ In the event of a medical emergency, I hereby authorize the Greater Missoula Family YMCA staff to administer First Aid, CPR, and/or seek out the appropriate, necessary medical attention.

_____ I understand that if my child needs medication that I must fill out the appropriate medication permission forms and provide them, any medication (in its original container), and appropriate administration instructions to the YMCA staff.

_____ I have reviewed and agree to abide by Greater Missoula Family YMCA policies.

_____ I agree not to hold the Greater Missoula Family YMCA liable if my child is injured while participating in Greater Missoula Family YMCA child care activities.

_____ I understand that I must contact the Director of School Age Programs by 12:00 p.m. if my child will be absent from a regularly scheduled program day.

_____ I understand that my child must be picked up by 6:00 pm.

_____ I understand that the Missoula Police Department will be called should my child not be picked up and should the Missoula YMCA be unable to reach me or our emergency contacts by 6:30 p.m.

_____ I understand my child's participation in the program may be temporarily or permanently discontinued without refund if their behavior becomes uncontrollable or violent.

_____ I completed the entire emergency form and have provided all available contact information.

_____ I understand that my child will not be released to anyone whose name is not listed on the emergency form. I understand proper identification must be presented at every pickup.

_____ If a parent of a child is not allowed custody or personal information of any kind, I will notify the Greater Missoula Family YMCA in writing and with proper court documentation.

_____ I understand that a written notice is required two weeks in advance for all schedule changes and/or cancellations.

Doctor's Name: _____ Phone Number: _____

Parent/Guardian Signature: _____ Date: ____ / ____ / ____

Parent/Guardian Name (please print): _____



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PAYMENT AUTHORIZATION FORM

This form is required for all Y After School applicants

The adult listed on this form will be responsible for payments and will be the Missoula Y's point of contact for all payment-related correspondence.

Participant's Name: _____ Program: _____

Primary Adult: _____ Date: ____/____/____
Last First M.I.

Mailing Address: _____

City: _____ State: _____ ZIP: _____ Phone: _____

Payment Method: (Please choose one)

_____ Monthly EFT/ Bank Draft (Please attach a voided check.)

_____ Monthly Credit/Debit (Please complete the information below.)

Type of Card: _____ Number: _____ Expiration Date: ____/____/____

Payment Authorization:

_____ I authorize my financial institution to honor drafts drawn by the Greater Missoula Family YMCA on my account. Drafts from my account will be deducted as scheduled. The amount drafted will be the current amount due on my account.

_____ I understand that EFT/ bank drafts (if paying by voided check) are administered by a third-party company, Daxko, and that any unsuccessful draft will be charged a non-refundable fee of up to \$30. If Daxko is unable to collect dues from my account after 30 days, it is my responsibility to make payment to the YMCA for all fees due, including any fee not covered by my financial institution.

_____ I understand that credit card drafts are administered by a third-party company, Daxko, and that any unsuccessful draft attempts will incur a non-refundable fee of up to \$30. It is my responsibility to settle any past-due balances and incurred fees with the YMCA or Daxko upon notice.

_____ I understand that I will be notified of any monthly program rate changes. I understand all deposits are non-refundable.

_____ I understand that I must give the Greater Missoula Family YMCA a 30-day written notice for any changes to my account name, account number, and/or financial institution, and two weeks' written notice for changes to program enrollment status and/or termination of services.

I agree to all terms and conditions listed above.

Primary Adult Signature: _____ Date: ____/____/____

Office Use Only:

Date of First Draft: ____/____/____ Date Entered in Daxko: ____/____/____ Staff Initials: _____

Financial Assistance: Yes, Family Yes, Individual No

UPDATED: APRIL 2021



REQUIRED FOR BEST BEGINNINGS FAMILIES ONLY

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BEST BEGINNING SCHOLARSHIPS

GREATER MISSOULA FAMILY YMCA

Welcome to Missoula Y After School! Financial assistance is available to qualifying families. There are two types of assistance available: Best Beginnings Child Care Scholarships and Missoula Y Financial Assistance.

Best Beginning Child Care Scholarships

The Best Beginning Child Care Scholarship is a state program that provides assistance to qualifying families in need of child care. Best Beginnings scholarships must be completed and turned into Child Care Resources. Applications and information about Child Care Resources can be found online at www.childcareresources.org/families/paying-for-child-care/.

Missoula Y Financial Assistance:

Families interested in Missoula Y Financial Assistance **must apply for Best Beginnings first**. Families who do not qualify for Best Beginnings scholarships may qualify for Missoula Y Financial Assistance. Please submit a Best Beginnings scholarship application to Child Care Resources prior to seeking Missoula Y Financial Assistance.

To apply for Missoula Y Financial Assistance, please fill out a financial assistance application available at the Welcome Center or online at ymcamissoula.org/financial-assistance. Forms and all required documentation must be received a minimum of 7 days prior to the start of after school in order to be considered. For more information on financial assistance, please call the Missoula Y at 721-9622.

The following information applies only to families receiving Best Beginnings scholarships.

_____ I understand that I am responsible for setting up and paying all co-pays that Child Care Resources (CCR) and/or the Greater Missoula Family YMCA establishes for the After School Program.

_____ I understand that I am responsible for completing and returning all required paperwork to CCR prior to my child(ren) starting the After School Program.

_____ I understand that my Greater Missoula Family YMCA co-pay may be higher than the co-pay listed on my Best Beginnings certification plan.

_____ I understand that my co-pay will increased if my child's attendance does not meet the amount of approved hours on my certification plan.

Parent/Guardian Signature: _____ **Date:** ____/____/____

Parent/Guardian Name (please print): _____



OPTIONAL

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PHOTO/ AUDIO VISUAL/NARRATIVE RELEASE

I am 18 years of age or older and, if not, my Parent/Legal Guardian has also signed below.

My Consent. For my participation in activities to be conducted by the National Council of Young Men's Christian Associations of the United States of America (YMCA of the USA), and/or the Greater Missoula Family YMCA (YMCA), I give my consent, now and for all time, to YMCA of the USA, YMCA and collaborating third parties to make, reproduce, edit, broadcast or rebroadcast:

- video film or footage of me,
- sound track recordings of me
- photo reproductions of me
- any narrative account of my experience

My consent gives permission to use the above materials for publication, display, sale or exhibition in promotions, advertising, education and legitimate business uses. Use includes reproductions in any form and media, adaptations and/or revisions, throughout the world and forever.

I understand and agree there may be no compensation for this, and I will not make any claim for payment of any kind. I may, or may not be, identified in such reproductions; however, my name will not be used to endorse any particular commercial products or commercial services.

Ownership, Confidentiality, and Shared Use. With respect to any of the above uses, I further agree:

- All uses shall belong to YMCA of the USA and YMCA and either may share them with others;
- There is no obligation of confidentiality
- YMCA of the USA, YMCA, and collaborating third parties will not be liable for any use or disclosure to a third party
- YMCA of the USA and YMCA shall exclusively own all known or later existing rights to the uses worldwide.
- YMCA of the USA and YMCA can use any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account for any purpose and without compensation to me.

Release from Liability. I agree that my consent is irrevocable. I hereby release and discharge YMCA of the USA, YMCA, their related parties and those they have given permission to use the above, from any and all claims, actions, lawsuits or demands of any kind arising out of my consent, the use, or the shared use of the above materials.

Participant's Printed Name: _____ Age: _____

Address: _____

Phone Number: _____ Email Address: _____

Participant Signature (if 18+): _____ Date: _____

I am the Parent/Legal Guardian of _____. For the consideration contained herein, I hereby consent to the foregoing on behalf of my minor child.

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian's Printed Name: _____



REQUIRED

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WAIVER, ACKNOWLEDGEMENT AND RELEASE [MINORS]

Read carefully and completely before signing

On behalf of my minor child/children, I hereby acknowledge and agree that participation in the sports, programs, activities and recreational opportunities at and through the Greater Missoula Family YMCA ("Missoula Y") comes with inherent risks. I understand and agree that the risks include, but are not limited to (1) slips, trips, falls, (2) aquatic injuries, (3) athletic injuries, and (4) exposure to bodily fluids, sweat, and/or illness caused by exposure due to bacteria or viruses. I understand and agree, pursuant to Montana Code Annotated ("MCA") Section 27-1-753, as participants in the sports and recreational opportunities offered at the Missoula Y, to assume the inherent risks in those sports or recreational opportunities, whether those risks are known or unknown and that the Missoula Y is not responsible for all injury, illness or death to my minor child/children or damage to their property that result from the inherent risks in those sports, programs, activities and recreational opportunities.

This Waiver, Acknowledgement and Release includes, but it not limited to, illness or damages arising from the novel coronavirus, and the disease it causes, COVID-19. I understand that this is a contagious virus, and governmental authorities recommend physical social distancing as a means to reduce the spread of this virus, which can lead to severe illness, injury, disability and death. Participating in Missoula Y programs and accessing Missoula Y facilities may incur exposure to viruses. The Missoula Y works to reduce the potential for exposure and spread, but exposure to viruses is an inherent risk of participation in the sports, programs, activities and recreational opportunities offered at and through the Missoula Y.

By signing this document, I am waiving my minor child/children's right to a jury trial to hold the Missoula Y legally responsible for any injuries, illness or damages resulting from risks inherent in the sports, programs, activities and recreational opportunities offered at or through the Missoula Y, and any damages they may suffer due to the Missoula Y's ordinary negligence that are the result of the Missoula Y's failure to exercise reasonable care.

Execution of this Waiver, Acknowledgement and Release [Minors] is in compliance with and not prohibited by or subject to the provisions of MCA Section 28-2-702. Nothing herein precludes an action based upon injury, illness, damages or death which results from something other than the inherent risk from participation in the sports, programs, activities and recreational activities as waived and released herein. In consideration of my participation in the sports, programs, activities and recreational opportunities at the Missoula Y, I hereby do release, on behalf of myself, my heirs, representatives, executors, administrators and assigns, to the extent allowed by law, the Missoula Y, and its officers, directors, employees, volunteers, agents, and insurers from any claims, causes of action or demands of any nature arising the inherent risk of my voluntary participation at and use of the facilities of the Missoula Y.

I certify that my date of birth is _____ (mm/dd/yyyy) and I am of lawful age and fully legally competent to sign this Waiver, Acknowledgement and Release on behalf of my minor child/children, all of whom are named below (add additional sheet if needed). I further understand that the terms of this agreement are legally binding and certify that I am signing this agreement, after having carefully read it, of my own free will.

Child/children's legal names and date of birth: (1) _____

(2) _____ (3) _____

IN WITNESS WHEREOF, this instrument is duly executed this **date:** _____

Parent/Guardian Signature

Parent/Guardian Name (print clearly)



REQUIRED

25

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Institution or Facility Name:

Part 1. Name of Child(ren) Enrolled:

CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.

Full names of all household members

Part 2. Benefits: If any member of your household received [SNAP], [FDPIR] or [TANF cash assistance], provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 3. NAME: CASE NUMBER:

Part 3. If any child you are applying for is homeless, a migrant, or a runaway, call the State agency for instructions.

Part 4. Total Household Gross Income—You must tell us how much and how often (whole dollar amounts, please)

Table with 5 columns: A. Name, B. Gross income and how often it was received, 1. Earnings from work before deductions, 2. Welfare, child support, alimony, 3. Pensions, retirement, Social Security, SSI, VA benefits, 4. All other income. Includes a row for 'Total number in household' and an example row for 'Jane Smith'.

This section required for all forms listing income in Part 4:

Last four digits of Social Security Number: X X X - X X - ___ ___ ___ □ I do not have a Social Security Number

Part 5. Signature (Adult must sign)

An adult household member must sign this form.

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: Print name:

Date:

Address: Phone Number:

City: State: Zip Code:

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:		
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	

Part 7. Decline to provide information

I choose not to provide information about my household size and income.

Signature of Adult Household Member

Date

*****This Section is to be completed by the Child Care Institution – Determination of Eligibility*****

Completion of this section is required for the institution to claim meals at the free or reduced rate for the child/children listed in Part 1: Name of Child(ren) Enrolled.

Number of persons in the household: _____

Total income \$ _____ Per: Week Every 2 Weeks Twice A Month Month Year
(Annual Income Conversion: weekly x 52, every 2 weeks x 26, twice a month x 24, monthly x 12)

Categorical Eligibility: Free Reduced Paid Tier I Tier II

Required: Determining Official's Signature: _____ Date: _____

Additional official signatures are recommended but not required.

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance for Needy Families (TANF) case number for the participant or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: "In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by (1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) Fax: (202) 690-7442; or (3) Email: program.intake@usda.gov. This institution is an equal opportunity provider."

Head Start: Children who are enrolled in the Federal Head Start Program receive meal benefits in the CACFP without further application or eligibility determination. Acceptable documentation includes a current approved Head Start application or a written, signed and dated statement or roster from a Head Start official. [USDA Memos CACFP 7-2008 and CACFP 10-2008]

Emergency Contact and Consent



This form must accompany staff when children are away from the childcare site

REQUIRED

Child's Name (First, Last)		
Date of Birth		
ALLERGY ALERT Does your child have allergies? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list all allergies in required box.		
Parent or Guardian Contact Information		
Name (First, Last)		Relationship
Home Address (Street, City, Zip)		
Primary Phone	Email Address	
Address (Street, City, Zip)		Work Phone
Name (First, Last)		Relationship
Home Address (Street, City, Zip)		
Primary Phone	Email Address	
Address (Street, City, Zip)		Work Phone
Required Emergency Contact Information – person other than parent or guardian that is authorized to pick up child		
Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship
Required Medical Information		
Primary Medical Care Provider		Phone
Health Concerns (Please explain)		
Allergies		
Parent or Guardian Authorization		
In an emergency, the child care facility has my permission to provide or obtain emergency medical treatment including transporting child by ambulance or vehicle if necessary. The parent/guardian of the child will be notified as soon as possible.		
Parent/Guardian Signature		Date
<i>(This form must be completed and signed annually)</i>		

**NON-INGESTIBLE
OVER THE COUNTER MEDICATION
AUTHORIZATION FORM**

TO BE COMPLETED BY PARENT

Child's Name _____ Date of Birth ____/____/____

Program Name _____

**I give permission for the administration of the following non-ingestible over the counter medications
(mark all that apply):**

Diaper Rash Cream/Ointments _____

Insect Repellent _____

Sunscreen _____

Cortisone/Anti-Itch Creams/Ointments _____

Medicated Lip Treatments _____

OTC Antibiotic Creams/Ointments _____

Burn Creams/Sprays _____

Other Non-Ingestible OTC's: (Please Specify) _____

To administer a non-ingestible over the counter medication:

- The medication must be brought to the day care facility from the parent;
- The medication must be in its original container, with a legible label, and expiration date of medication;
- The child's name must be on the original container

Special handling/storage Instructions _____ Refrigeration? _____

Parent/Guardian Signature (required) _____ **Date:** ____/____/____

*** This document must be updated on an annual basis.**

Unused Medication: (check one) Returned to Parent Y N Discarded appropriately Y N

By: _____

Date: ____/____/____

***Keep in the child's file when medication is finished.**

STATE OF MONTANA— CHILD CARE FACILITY/SCHOOL **REQUIRED** 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 7 th 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] <input type="checkbox"/> Check here if child has documentation of disease					
Hepatitis B					
Pneumococcal Conjugate vaccine (PCV13)					

ACIP* Recommended Vaccines <small>*Advisory Committee on Immunization Practices, U.S. Centers for Disease Control and Prevention</small>	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

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 immunization.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

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