



VALLEY ADVENTIST CHRISTIAN SCHOOL
MONTANA CONFERENCE ELEMENTARY SCHOOLS
K-8 ENROLLMENT FORM
2024-25



<i>Office Use Only</i>	School Name:		School Entry Date:			
	Student ID:	<input type="checkbox"/> Birth Certificate: <input type="checkbox"/> Physical	<input type="checkbox"/> Immunizations Received <input type="checkbox"/> Financial Agreement Form	<input type="checkbox"/> Record Requested Date: <input type="checkbox"/> Record Received Date:		
I. Student Information						
1. (LEGAL NAME ONLY) Last Name		First	Middle	Suffix (Jr, II, III)		
2. Other name(s) used		3. Is student a US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No				
4. Grade	5. Age	6. Birth Date	7. Birth Place (city, state)		8. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
9. Church Affiliation Is student baptized? <input type="checkbox"/> Yes <input type="checkbox"/> No Date		10. Home Phone		11. Race (Select one or more) <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native		
12. Home Address		City	State	Zip Code		
13. Mailing Address (if different than above)		City	State	Zip Code		

II. Parent and Emergency Contact Information								
14.	PARENT/ GUARDIAN	<input type="checkbox"/> Lives with Student <input type="checkbox"/> Student's Legal Guardian <input type="checkbox"/> SDA Member	Last Name		First Name			
			Relation to Student	Email Address		Occupation		
			Mailing Address			City	State	Zip Code
			Cell Phone:		Home Phone:		Work Phone:	
			Church Affiliation:					
15.	PARENT/ GUARDIAN OTHER	<input type="checkbox"/> Lives with Student <input type="checkbox"/> Student's Legal Guardian <input type="checkbox"/> SDA Member	Last Name		First Name			
			Relation to Student	Email Address		Occupation		
			Mailing Address (if different than above)			City	State	Zip Code
			Cell Phone:		Home Phone:		Work Phone:	
			Church Affiliation:					
16. LOCAL EMERGENCY CONTACT(S) (Other than Parent/Guardian)	Last Name		First Name					
	Relation to Student	Home Phone	Work Phone		Cell Phone			
	Last Name		First Name					
	Relation to Student	Home Phone	Work Phone		Cell Phone			
17. PHYSICIAN	Name			Phone				
18. DENTIST	Name			Phone				

OFFICE ONLY Student Name: _____ Grade: _____ Teacher: _____ Student ID: _____

III. Siblings

19. Complete this section only if applicable. Include only siblings who are currently in Grades PK-8 in this school.

Sibling #1 full name:	Grade:	School Name:
Sibling #2 full name:	Grade:	School Name:
Sibling #3 full name:	Grade:	School Name:
Sibling #4 full name:	Grade:	School Name:

IV. Previous Schools

20. Last Elementary School Attended			Grade
21. Address	City	State	Zip

V. QUESTIONS FOR PARENTS

22. Has student ever received service from or been involved in: (check all that apply):

- Special Education
 Title I
 Reading Tutor
 Speech Therapy
 Gifted Program
 English 2nd Language
 Behavior Management
 Counseling
 Other:

23. Has this student ever been under long term suspension or been suspended from school? Yes No

24. **Legal Bindings:** Please list any legal binding information, including restraining orders, custody agreements that are pertinent to this student and his/her safety: (copy of the legal documentation is required).

25. **Is there any other information that would help us better serve your student?**

26. Continuing Consent to Treatment and Authorization to Release Information

I, the undersigned parent/guardian of the above named student, do hereby consent to any x-ray, examination, anesthetics, medical or surgical diagnosis or treatment, and hospital service that may be rendered to said minor under the general or special instruction of the above named physician or a licensed hospital. It is understood that reasonable effort will be made to contact the physician listed above before any other physician is called.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize the school or the physician to exercise their best judgment as to the requirement of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the physician named above or the school.

I hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to the student accident insurance carrier or its representative any and all information with respect to any illness, medical history, consultation, x-ray, or treatment, and copies of all hospital or medical records. A copy of this authorization shall be considered as effective and valid as the original.

Signed: _____ Date: _____

Witness: _____ Date: _____

27. Directory of Students

I give permission to publish parent & student names, addresses, phone number, and student's grade level in school directory.

Yes No

28. Photographic Release

I give permission to use photos for publicity, promotional, and school/conference use.

Yes No

OFFICE ONLY

Student Name: _____

Grade: _____

Teacher: _____

Student ID: _____

Student Name:

Health and Medical Information

Allergies: Bee Sting Food Environment Latex Medication Other

Name of Medication(s): _____

*needs medication at School takes medication at home

Describe reaction and intervention: _____

List other allergies: _____

Asthma:

Name of medication(s) _____

*needs medication at School takes medication at home carries inhaler on person inhaler in school office

Attention Deficit Disorder:

Name of medication(s) _____

*needs medication at School takes medication at home diagnosed but no medication

Diabetes: *Insulin dependent/needs school program set up *Self manages snacks, diet, testing, coverage

Headaches:

Name of medication(s) _____

Seizures:

Name of medication(s) _____

*needs medication at School takes medication at home history of seizure but not currently on medication

Other Medications: *needs medication at School takes medication at home

Diagnosis: _____

Name of medication(s) _____

Hearing Concerns:

(Please explain)

Vision Concerns:

(Please explain)

Physical Restrictions:

*Uses mobility aide (wheelchair, walker, crutches, etc.)

*Restricted because of _____

Must avoid this/these activities _____

(Doctor's letter is required for some P.E. adaptations)

Other: Describe health history (operations, serious accidents, and serious illness)

Diseases/Conditions: If known indicate the year of the disease/condition when applicable:

Chicken Pox Measles (Rubella) Mumps Rubella (3 day) Scarlet Fever Sinusitis
 Eczema Whooping Cough Heart Disease Rheumatic Fever Kidney/Bladder Disorder Congenital Condition

Other (please describe): _____

***Note:** If medication is needed, the parent must complete a medication authorization form before the first dose of medication can be given at school. This health concern information may be shared with school personnel as necessary to benefit the health and safety of this student and others. Please keep school staff informed as to changes to the information so the student's records can be updated as needed.

Parent/Guardian signature (required)

Date

OFFICE ONLY

Student Name: _____

Grade: _____

Teacher: _____

Student ID: _____



Valley Adventist Christian School

1275 Helena Flats Rd., Kalispell, MT 59901

Annual Technology Consent Form (Google, Vocab A-Z, etc)

Dear Parent(s)/Guardian(s),

Valley Adventist Christian School Board is committed to fostering learning environments where students can exemplify the competencies for 21st century learning (Christian Character, Critical Thinking and Problem Solving, Creativity and Innovation, Collaboration, Communication, and Technology) in a manner that is acceptable to the Christian life. Through the implementation of innovative instructional practices, this will entail the equitable and safe use of technology. The intent of this form is to communicate the technological services we offer and to get signed consent before access is granted for any of the digital tools we support.

VACS makes available digital devices, resources and tools to students and teachers:

- GSuite for Education
- Lightspeed Relay
- Lightspeed Classroom
- Vocab A-Z
- Digital Devices as defined in our technology ecosystem such as Chromebooks, Desktops, Laptops, and printers.

GSuite for Education

GSuite for Education is a suite of tools that enable students to create, share, and edit files on the web using a computer, tablet, or smartphone. These tools function in a secure and private environment that is maintained by VACS. Not only do these tools serve as an extension of the physical classroom, they allow students the convenience of accessing their work 24/7 from anywhere there is an Internet connection. Various types of tasks conducive for word processing, spreadsheets, web publishing, presentations and so on can be completed by students using these tools. Please note that elementary students do not have access to email while students in high school are able to communicate via email with other students and teachers.

Lightspeed Relay

Relay by Lightspeed Systems will Filter, Manage, Monitor, Protect, and Analyze across operating systems, on and off network for a truly comprehensive platform. Relay allows VACS to allow or block sites and apps, control web access, monitor and report on all activity; get everyone the information and controls they need.

Relay also shares student activity reports on a weekly basis to keep parents in-the-know, provides a holistic view of a child's digital learning habits, and even helps parents nurture an interest they didn't even know their student had.

Lightspeed Classroom

With Lightspeed Classroom Management™, teachers can keep their students logged in, participating, and focused whether in-person or at a distance. Advanced AI technology gives teachers real-time visibility and control of their students' digital workspaces and online activity. Educators can safely message a distracted student, redirect their browser, close windows and tabs, and enable screen sharing for collaboration between students.

Parent Consent Form for Board Approved Digital Tools

By signing below, I confirm that I have read and understand the following:

Student Acceptable Use:

1. Educational Use—These accounts are for educational use only. They will be used to support school projects and research that reflect the goals and objectives set out by the teacher and the school. Students are not to make use of their accounts for personal, recreational, social, political or commercial activities that are not school or curriculum related.
2. Privacy and Security—Each participating student is given their own individual accounts that are password protected. Students are not permitted to share their accounts or gain unauthorized access to another account at any time. Students will not attempt to harm or destroy data of another user. Be aware that teachers and school administration have the capability and the right to monitor any and all messages posted within board sponsored tools. Students are responsible for all messages sent via their account. Students are asked to refrain from posting personal contact information such as home/email addresses, phone numbers, for themselves and others using these platforms.
3. Communication—When communicating with these digital tools, it is important that students conduct themselves using good digital discipleship in a respectful, professional and constructive manner. Students will not use these platforms to post any obscene, discriminatory or offensive matter. Postings that are abusive, use inappropriate language, are harassing or can be deemed as bullying will not be tolerated.
4. Violations—Students are being given the privilege of access to these platforms. Violations or inappropriate use could result in a cancellation of those privileges as well as disciplinary action from the school administration and/or the police. The system administrators may close an account at any time when deemed necessary. See appendix A for examples of inappropriate/unlawful activity.

Students must report immediately any threatening, obscene, or harassing messages to school staff.

My child's first name and last initial will be used as their personal VACS account identifier. No private or confidential student information is stored within the GSuite for Education or Seesaw environments.

I give permission for my child to use digital tools supported by VACS.

I do not give permission for my child to use digital tools supported by VACS.

Name of Student: _____ Student ID or Grade: _____

Name of Parent/Guardian: _____

Parent/Guardian Signature: _____ Date: _____



Elementary - Student Consent Form for Board Approved Technology

This is an agreement for elementary students with respect to the appropriate use of technology at VACS

Student Name: _____ School Name: _____

I agree to:

- take proper care of the computer/device at all times.
- keep food and drinks away from the computer/device.
- keep any object away from the computer/device that may cause damage.
- use the computer/device only to help me learn as approved by my teacher(s).
- respect the privacy of other users/students on the Valley Adventist Christian School network and not attempt to login under their user ID.
- never knowingly enter into the operating system of the device or file server to alter system settings or configurations.
- be mindful about the issues of plagiarism and copyright.
- never transmit, by electronic means including e-mail, any information or messages which will compromise the reputation of the school or other persons; including bullying.
- never release my password to anyone other than my principal, teacher(s) and/or parents.
- Use the internet only for school/classroom activities as approved by the teacher.
- Only use any personally owned electronic device (such as a cell phone) when directed by my teacher/Principal.
- Neither a school, nor VACS, nor its agents, assume responsibility for the loss, recovery, damage, repair or replacement of any personally owned electronic device brought onto school premises, on school excursions or while the personally owned electronic device has been confiscated.

I understand that I may be subject to appropriate consequences for breaking this agreement including loss of privileges and/or suspension.

Signed
Student: _____

Name
Parent/Guardian: _____

Parent/Guardian:
Signature _____

Date: _____





Valley Adventist Christian School

1275 Helena Flats Road, Kalispell, MT 59901 (406) 752-0830

REQUEST FOR TRANSFER OF EDUCATIONAL RECORDS

TO: Valley Adventist Christian School

1275 Helena flats Road

Kalispell, Montana 59901

FROM: School _____

Street _____

City _____ State _____ Zip _____

RE: Student _____

Address _____

Birth date _____ Grade _____

School Official _____

As the parent/guardian of the above named student, I hereby grant my permission for the release of my child's educational records to Valley Adventist Christian School. I acknowledge notification of this transfer of records, and I understand that the information transferred will be treated in a confidential manner and will not be transmitted to a third party without my consent.

Signature of Parent/Guardian _____

Date _____ Current Address _____

Student Pick-up Consent Form

Valley Adventist Christian School

The Valley Adventist Christian School adopts and enforces the following guidelines to ensure the safety of your child

1. No child will be allowed to leave the school grounds with an adult other than their parents, without the written permission of his/her parent(s) or guardian.
2. No child will be allowed to leave the school grounds with a stranger.
3. Anyone who has a known history of sexual molestation or any type of sexual impropriety will not be allowed to work with children in this school.

In accordance with the above, please list the name, address, and phone number of each adult (other than yourself) who has your permission to leave the school grounds with your child. Students will not be allowed to leave the school grounds with persons not appearing on this list without a written note from you. In the case of an emergency, a personal phone call from you to the teacher, followed with a written note the following day will be acceptable. This note will be placed in the school files

Name	Address	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____	_____	_____
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VALLEY ADVENTIST CHRISTIAN SCHOOL

The primary goal at Valley Adventist Christian School is Christian education - an education that makes Christ real in your lives. Our desire is to prepare you for this world and for Heaven. For this reason, we ask that you read* the personal commitment below. When you understand and agree to follow these principles, please sign your name.

Thank you!

Valley Adventist Staff

* Parents may read the personal commitment to students so they understand what they are signing.

STUDENT COMMITMENT

- I understand that the Valley Adventist Christian School is a Christian school that is based on Christ-centered principles.
- I understand that my attendance at this Christian school is a privilege.
- I will respect in my words, actions and attitude:
 - God
 - Those in authority - parents, teachers, pastors, etc.
 - My fellow classmates
 - All property (mine, others, and the school's)
- I will promote harmony and peace.
- I will strive to do my best in my class responsibilities.
- I have read the Policy Handbook, giving careful attention to Section V found on pgs. 15-17, and will abide by it.
- I understand and agree that I will be held accountable throughout this school year for upholding these standards and Christian values.

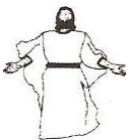
I have read the Personal Commitment and understand that I may give up the privilege to attend this school if I do not keep these commitments and any other regulations that may be considered necessary by the staff, administration or school board.

Student's Signature

Date

Parent's Signature

Date



"Whatsoever ye do, do all to the Glory of God."

1 Corinthians 10:31

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

- | | |
|---|--|
| <input type="checkbox"/> <i>Diphtheria, Pertussis, Tetanus (DTaP, DT, Tdap)</i> | <input type="checkbox"/> <i>Polio</i> |
| <input type="checkbox"/> <i>Measles, Mumps and Rubella (MMR)</i> | <input type="checkbox"/> <i>Varicella (chickenpox)</i> |
| <input type="checkbox"/> <i>Haemophilus Influenzae Type b (Hib)</i> | |

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 _____

PARENT/STUDENT 2022-23

STATEMENT OF POLICY AGREEMENT

By signing below, I verify that I have read the Valley Adventist Christian School handbook, have reviewed the policies and rules with my child, and both agree to adhere to VACS policies.

Parent Name _____

Signed _____

Child Name _____

Date _____

"Whatsoever ye do, do all to the Glory of God."

1 Corinthians 10:31

Vaccines Required for School Attendance, Preschool - 12th Grade



VACCINE	PRESCHOOL ¹	KINDERGARTEN - 12 TH GRADE
Haemophilus influenza Type B (Hib)	1 dose (given on or after the 1 st 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 4 th birthday) ^{3,4} Plus 1 dose of Tdap (prior to entering 7 th grade) ⁶
Polio (IPV or OPV)	3 doses	3 doses (one dose must be given on or after 4 th birthday) ³
Measles, Mumps, and Rubella (MMR)	1 dose (dose must be given on or after 1 st birthday)	2 doses (first dose must be given on or after 1 st birthday, and spacing between doses is 4 weeks)
Varicella "chickenpox" (Var)	1 dose (dose must be given on or after 1 st birthday) ⁶	2 doses (first dose must be given on or after 1 st birthday, spacing between doses is 12 weeks for children under 13 years, and 4 weeks for those older than 13 years) ^{5,6}

¹Per 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.

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

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

⁴A 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.

⁵While 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.

⁶As 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.

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 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 *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 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

FORM No. IZ HES101 (Revised 07/2015)

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

Name of Patient: _____

Date Exemption Ends: ____/____/____

Vaccine	
PCV (not required for school attendance)	<p>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)</p> <p>Precautions</p> <input type="checkbox"/> Moderate or severe acute illness with or without fever
Hib	<p>Contraindications</p> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <input type="checkbox"/> Age <6 weeks
MMR	<p>Contraindications</p> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <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) <input type="checkbox"/> Pregnancy
Varicella	<p>Contraindications</p> <input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component <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) <input type="checkbox"/> Pregnancy
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



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

- | | |
|---|--|
| <input type="checkbox"/> <i>Diphtheria, Pertussis, Tetanus (DTaP, DT, Tdap)</i> | <input type="checkbox"/> <i>Polio</i> |
| <input type="checkbox"/> <i>Measles, Mumps and Rubella (MMR)</i> | <input type="checkbox"/> <i>Varicella (chickenpox)</i> |
| <input type="checkbox"/> <i>Haemophilus Influenzae Type b (Hib)</i> | |

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 _____

Valley Adventist Acceptance Process

Formal application must be made for all students by completing an application form. Acceptance is subject to the decision of the school board. Valley Adventist requests interviews and/or letters of recommendation from a former teacher, current pastor and or family friend. The references should not be a relative of the student. Valley Adventist may review previous school behavior and academic performance. Previous and current parental interaction with schools may also be a consideration. All students are in a period of probation for the first six weeks of each school year. *All paperwork is due at registration, or it must be arranged for completion by September 15 for students to continue school.* The following documents must be submitted:

1. Proper school records verifying past education
2. Immunization and health records
3. Birth certificate
4. Financial agreement
5. Promise of parental support and involvement
6. Registration papers
7. Signed student commitment
8. Signed technology consent
9. Reference list

Note: VACS will not accept students who have a poor behavioral record or who have been suspended or expelled from another school except in special circumstances reviewed and approved by the school board. (HB p.8)

Reference Contact List

Current or Previous Teacher:

Name: _____

Phone: _____

Pastor:

Name: _____

Phone: _____

Family friend:

Name: _____

Phone: _____

2024-25 SCHOOL YEAR CALENDAR – 1080 RQD HOURS

August 11	Registration -final paperwork due (1-5pm)
August 20	First Day of School/Field trip to Lawrence Park
August 22	Home & School Parent meeting (6:00pm)
September 2	Labor Day – No School
September 9-12	Outdoor School – No school K-4
September 23-26	MAP Testing
October 14	Music performance @ Kalispell SDA Church (required)
October 17-18	State Teacher Meetings – No School (Thursday)
October 25	End of 1st Quarter
November 2	Parent/Teacher Conferences- Noon Release
November 8	Community Service School Day 9:00-1:00
Nov 6-Dec 8	Swimming lessons at The Wave (Monday/Wednesdays)
November 25-28	Thanksgiving Vacation- No School
December 2	School Resumes
December 6	Ice Skating- School Day (3 hrs)
Dec 23-Jan 2	Christmas Vacation- No School
January 6	School Resumes
January 10	Winter sports??
January 13	Winter Teacher In-service- No school
January 17	End of 2 nd Quarter
January 12	Ski at Blacktail Mtn. – School Day
January 27-30	MAP Testing
January 25	Music performance @ Kalispell SDA Church (required)
January 31	Snow Sports– School Day
February 7	Snow Sports – School Day
February 21	Snow Sports – School Day
March 14	Snow Sports – School Day
March 21	End of 3rd Quarter
March 24-27	Spring Break- No School
March 31	School Resumes
March 28	Parent/Teacher Conferences- Noon Release
April 11	Community Service School Day 9:00-1:00
April 27	Music performance @ Kalispell SDA Church (required)
April 28-May 1	MAP Testing
May 26	Memorial Day – No School
May 29	Last Day of School, End of 4th Quarter
May 29	8 th Grade Graduation
May 29	End of 4 th Quarter – Noon Release

Note: This is a proposed calendar, pending approval by the superintendent. Social events will be added, such as swim lessons, ski lessons, field trips, music performances, Christmas program, community service projects, etc.

Valley Adventist Christian School

Tuition and Fees

Grades K-8

2024-25

Registration for all students	First month's tuition (Due August 20 th , 2024) \$100 discount per family if registered by March 15 th , 2024
Tuition Non-constituent* student	\$458.00 per month (\$4,580.00 for the year)
2 nd student	\$385.00 per month (\$3,850.00 for the year)
3 rd student	\$328.00 per month (\$3,280.00 for the year)
4 th student or more	\$128.00/student/month (\$1,280.00/student for the year)
Tuition Constituent student	\$377.00 per month (\$3,770.00 for the year)
2 nd student	\$320.00 per month (\$3,200.00 for the year)
3 rd student	\$271.00 per month (\$2,710.00 for the year)
4 th student or more	\$128.00/student/month (\$1,280.00/student for the year)
Hot Lunch	Included in tuition (once per week)
Basic Supplies	Included in tuition
Swimming	Included in tuition 4 hours of lesson (8 days) October - November 2024 at The Wave
Skiing	Included in tuition 8-16 hours of lesson January - March 2025
Outdoor School (Grades 5-8)	Registration fee included in tuition Fall 2024 at Camp Paxton on Seely Lake, MT
Ski the Summit (Grades 7-8)	\$200 (estimate) February 2025 at Mount Ellis Academy, Bozeman, MT

Transportation for off campus activities to be determined. Parents may be responsible for a portion of the transportation costs.

* A non-constituent student is one that is not affiliated with the Seventh-day Adventist Church. Constituent students are typically from families who are members of either the Kalispell or North Valley Seventh-day Adventist church.