



Request for Medical Exemption from State Assessments

[DISTRICT NAME] MEDICAL PROVIDER FORM

In Montana, state law and accreditation rules require all students to participate in the Board-approved grades and content specific state assessments. The Montana Office of Public Instruction (OPI) recognizes there may be circumstances beyond the school district's control when a student cannot be assessed at any time during the testing window due to a significant medical emergency (e.g., a student is hospitalized due to an accident). In rare occasions where a student is unable to participate in the assessments, the school must document these circumstances according to the OPI participation policies and report them in the MontCAS Application.

What is a Medical Exemption? Students may receive a medical exemption if they cannot participate in a state assessment during the testing window (including make-up dates) due to a significant qualifying medical event. Examples of a significant medical emergency include a serious car accident, hospitalization, severe trauma, mental health crisis that is dangerous to self or others, or placement in hospice care. Generally, if the student is able to receive instruction during the testing window, the student should be able to participate in assessment. An injured student can often participate in a state assessment with accommodations.

Note: This form is intended to assist school districts with the documentation for these qualifying medical reasons locally.

District Directions: Give this form to the medical professional (e.g., physician/mental health professional). Once signed, retain a copy for the student's records. Do not send this form to the OPI. School districts are encouraged to retain the medical reason documentation locally for a period of three years as the OPI reserves the right to audit districts to ensure compliance with the requirement to retain signed copies of all applicable forms for up to three years. Non-participation due to a medical reason must be determined between the family, medical provider, and the school district.

Provider Directions: After reading the information below, indicate whether or not you agree or disagree with each assurance, initial each statement, and sign and date the bottom of this form.

Student Information

Last Name:		First Name:		Middle Initial:	
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Medical Provider's Assurance on Recommended Medical Exemption:	Agree (Y/N)	Disagree (Y/N)
This student is experiencing a serious illness or medical emergency.	☐ Yes	☐ No
This is a rare and unique situation in which the student is unable, for medical reasons, to participate in any part of the state assessment.	☐ Yes	☐ No
This student cannot receive standard instruction or participate in state assessments during the testing window even with adjustments to their school schedule or location.	☐ Yes	☐ No
This student cannot take the state assessment, even with accommodations or other supports.	☐ Yes	☐ No
I am a licensed medical provider.	☐ Yes	☐ No

Medical Provider Information

Printed Name of Medical Provider:	
Signature of Medical Provider:	
Date:	