SUMMER PROGRAM REGISTRATION 2021

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2021 SONCCA SUMMER PROGRAM REGISTRATION PACKET

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Physical Form

Due to Covid-19, SONCCA will provide field trip permission forms, acknowledgement forms and lunch choices closer to the start of program. They will be available on our website and at the Summer program. Thank you for your understanding.

2021 SONCCA Summer Program Fee Schedule

Fees Are Weekly & All-Inclusive in Full Time, Full Day Schedules
Two-Week Minimum Registration Required
Program Operates June 28 - August 13, 2021

Full Time (4-5 days)

Schedule	Hours	Fee
Schedule I:	8:00 a.m. - 1:00 p.m.	$127
Schedule II:	1:00 p.m. - 6:00 p.m.	$127
Schedule III:	8:00 a.m. - 6:00 p.m.	$216

Additional Child Discount

Schedule	Hours	Fee
Schedule I:	8:00 a.m. - 1:00 p.m.	$116
Schedule II:	1:00 p.m. - 6:00 p.m.	$116
Schedule III:	8:00 a.m. - 6:00 p.m.	$191

Part Time (1-3 Days)

Schedule	Hours	Fee
Schedule I:	8:00 a.m. - 1:00 p.m.	$88
Schedule II:	1:00 p.m. - 6:00 p.m.	$88
Schedule III:	8:00 a.m. - 6:00 p.m.	$175

AM Coverage (per week) $25

Full Day Drop-Off Fee: $60
Half Day Drop-Off Fee: $40
Registration Fee: $20
Late Child Pick-Up Fee - $20.00/15 minutes
Late Tuition Payment Fee: $25.00

2021 SONCCA SUMMER PROGRAM PARENT AGREEMENT

Registration for: ______________________________

As parent/guardian of the above child, I hereby request SONCCA (Seymour-Oxford Nursery & Child Care Association, Inc.) to provide care for my child at the SONCCA-Seymour Middle School Location.

Please check all the appropriate schedules, times and days needed.

☐ **Week 1: June 28, 2021 - July 2, 2021**

☐ **Full Time (4-5 days)** ☐ **Part Time (1-3 days)**

☐ Schedule I: 8:00 a.m. - 1:00 p.m. ☐ Schedule II: 1:00 p.m. - 6:00 p.m.

☐ Schedule III: 8:00 a.m. - 6:00 p.m. ☐ AM Drop Off: 7:00 a.m. - 8:00 a.m.

☐ *Monday* ☐ *Tuesday* ☐ *Wednesday* ☐ *Thursday* ☐ *Friday*

☐ **Week 2: July 6, 2021 - July 9, 2021**

☐ **Full Time (4-5 days)** ☐ **Part Time (1-3 days)**

☐ Schedule I: 8:00 a.m. - 1:00 p.m. ☐ Schedule II: 1:00 p.m. - 6:00 p.m.

☐ Schedule III: 8:00 a.m. - 6:00 p.m. ☐ AM Drop Off: 7:00 a.m. - 8:00 a.m.

Monday Closed ☐ *Tuesday* ☐ *Wednesday* ☐ *Thursday* ☐ *Friday*

☐ **Week 3: July 12, 2021 - July 16, 2021**

☐ **Full Time (4-5 days)** ☐ **Part Time (1-3 days)**

☐ Schedule I: 8:00 a.m. - 1:00 p.m. ☐ Schedule II: 1:00 p.m. - 6:00 p.m.

☐ Schedule III: 8:00 a.m. - 6:00 p.m. ☐ AM Drop Off: 7:00 a.m. - 8:00 a.m.

☐ *Monday* ☐ *Tuesday* ☐ *Wednesday* ☐ *Thursday* ☐ *Friday*

☐ **Week 4: July 19, 2021 - July 23, 2021**

☐ **Full Time (4-5 days)** ☐ **Part Time (1-3 days)**

☐ Schedule I: 8:00 a.m. - 1:00 p.m. ☐ Schedule II: 1:00 p.m. - 6:00 p.m.

☐ Schedule III: 8:00 a.m. - 6:00 p.m. ☐ AM Drop Off: 7:00 a.m. - 8:00 a.m.

☐ *Monday* ☐ *Tuesday* ☐ *Wednesday* ☐ *Thursday* ☐ *Friday*

☐ **Week 5: July 26, 2021 - July 30, 2021**

☐ **Full Time (4-5 days)** ☐ **Part Time (1-3 days)**

☐ Schedule I: 8:00 a.m. - 1:00 p.m. ☐ Schedule II: 1:00 p.m. - 6:00 p.m.

☐ Schedule III: 8:00 a.m. - 6:00 p.m. ☐ AM Drop Off: 7:00 a.m. - 8:00 a.m.

☐ *Monday* ☐ *Tuesday* ☐ *Wednesday* ☐ *Thursday* ☐ *Friday*

☐ **Week 6: August 2, 2021 - August 6, 2021**

☐ **Full Time (4-5 days)** ☐ **Part Time (1-3 days)**

☐ Schedule I: 8:00 a.m. - 1:00 p.m. ☐ Schedule II: 1:00 p.m. - 6:00 p.m.

☐ Schedule III: 8:00 a.m. - 6:00 p.m. ☐ AM Drop Off: 7:00 a.m. - 8:00 a.m.

☐ *Monday* ☐ *Tuesday* ☐ *Wednesday* ☐ *Thursday* ☐ *Friday*

☐ **Week 7: August 9, 2021 - August 13, 2021**

☐ **Full Time (4-5 days)** ☐ **Part Time (1-3 days)**

☐ Schedule I: 8:00 a.m. - 1:00 p.m. ☐ Schedule II: 1:00 p.m. - 6:00 p.m.

☐ Schedule III: 8:00 a.m. - 6:00 p.m. ☐ AM Drop Off: 7:00 a.m. - 8:00 a.m.

☐ *Monday* ☐ *Tuesday* ☐ *Wednesday* ☐ *Thursday* ☐ *Friday*

(Continued on next page)

PAYMENT AGREEMENT:

Enclosed is the $20.00 non-refundable registration fee and other amounts I agree to pay. Please place a checkmark next to your choice.

☐ A non-refundable deposit of $50.00 per week registered, at the time of registration and the balance of $__________, with the first four weeks to be paid by June 11th, and a balance of $_________, for the last three weeks by July 16th.

☐ Full tuition of $_________ for weeks (circle weeks) 1-2-3-4-5-6-7 at the time of registration.

The registration and tuition fees are payable by check or money order made out to:
SONCCA, Inc., 256 Bank Street, Seymour, CT 06483

I understand that these fees are payable regardless of the number of days my child attends. I understand that I will be liable for any and all collection fees, legal fees and court fees incurred by SONCCA in its attempt to collect all tuition and fees as agreed upon in this registration contract. I have received a copy of the PARENT HANDBOOK or read the one on line, including the Discipline Policy, and agree to abide by the policies contained therein. I also grant permission to the following:

1. For the Site Supervisor or any other qualified staff member to take whatever steps may be necessary to obtain emergency medical care, if warranted. These steps may include, but are not limited to, the following:
   A) Administering emergency first aid (by State-approved first aid certified SONCCA personnel);
   B) Contacting the parent or guardian, either by calling them at their place of employment, or by attempting to contact them through any of the persons listed on the emergency information form. **(This form MUST be kept updated!);**
   C) Contacting the child's physician or dentist;
   D) Contacting another physician or calling an ambulance, if neither parent nor child's physician can be reached;
   E) Accompanying your child in the ambulance to the hospital emergency room you have selected, if possible, otherwise, taking your child to Griffin Hospital;
   F) Any expenses incurred will be borne by the parents.

2. For my child to use all of the playground equipment and to participate in all of the SONCCA program activities, unless exceptions are noted here:____.

3. For my child to leave the school premises under the supervision of a staff member for neighborhood walks or for field trips provided that I signed the specific permission slip for the planned activity. Means of transportation, if any, will be noted.

4. For my child to be included in photographs and evaluations associated with the program.

5. I understand that SONCCA will not be responsible for anything that may happen as a result of false information given at the time of enrollment or during program period.

6. I understand that parents are responsible for the daily signing in and signing out of their children and that SONCCA will not assume responsibility for any child not signed in by a responsible adult upon arrival in the morning.

7. Parents are expected to carry insurance for their children. SONCCA does not carry "medical payments for children" insurance or pay medical reimbursement.

8. I give permission for financial information to be shared with __________________________, who is responsible for partially or totally paying for my child's tuition fee.

<u>9. IF BOTH PARENTS DO NOT SIGN THIS PAGE AND BOTH PARENTS WANT TO BE ALLOWED TO PICK UP THEIR CHILD, THE OTHER PARENT'S NAME MUST BE INCLUDED ON THE AUTHORIZED PICK-UP PAGE.</u>

______________________________	______________________
Parent/Guardian Signature	Date
______________________________	______________________
Parent/Guardian Signature	Date

2021 SONCCA SUMMER PROGRAM REGISTRATION FORM

Child's Name: ______________________________

Address: ______________________________ Phone: ______________

Age: ________ Date of Birth: ______________ Gender: ______________

Grade Entering in 9/21: ____________ School: ______________________

T-Shirt Size:
☐ Youth Small (6-8) ☐ Youth Medium (10-12) ☐ Youth Large (14-16)
☐ Adult Small (34-36) ☐ Adult Medium (38-40) ☐ Adult Large (42-44)

Mother's (Legal Guardian's) Name: ______________________________

Date of Birth: (verification purpose) ________ Address if different from above: ______________________

____

Place of Employment: ______________________________

Business Address: ______________________________

Cell Phone: ______________ Business Phone: ______________

Father's (Legal Guardian's) Name: ______________________________

Date of Birth: (verification purpose) ________ Address if different from above: ______________________

____

Place of Employment: ______________________________

Business Address: ______________________________

Cell Phone: ______________ Business Phone: ______________

Child's Physician: ______________________ Phone: ______________

Address: ______________________________

Child's Dentist: ______________________ Phone: ______________

Address: ______________________________

Hospital Preferred: ______________________________

Health Insurance Company: ______________________ Policy #: ______________

Please provide an e-mail address where you would like to receive correspondence.

E-mail: ______________________________

______________________ ______________
Parent/Guardian Signature Date

______________________ ______________
Parent/Guardian Signature Date

ADMINISTRATIVE OFFICE USE ONLY:

Date Starting Program: ______________________
( ) Tuition Deposit Amount Received $ ____________ ( )Check # ____________
( ) Registration Fee Enclosed ( ) Check # ________

Pro Care ________ Billing ______________

2021 SONCCA SUMMER PROGRAM NOTIFICATION & CHILD RELEASE AUTHORIZATION

Child's Name: ______________________________

If SONCCA cannot reach me, I authorize the following person(s) to be notified. I also authorize SONCCA to release my child to any of the following person(s). This (these) individual(s) have my permission to sign him/her in or out in the event that I am unable to do so. State regulations require that at least one person other than parents be listed (at least one of the persons listed must be local, within a 10-minute drive, and available for an emergency pickup). **Please cross out and initial any black areas, changes can only be made in person.**

Name: ______________________________
Relationship: ______________ Cell Phone: ______________
Address: ______________________________
Business Phone: ______________ Home Phone: ______________

Name: ______________________________
Relationship: ______________ Cell Phone: ______________
Address: ______________________________
Business Phone: ______________ Home Phone: ______________

Name: ______________________________
Relationship: ______________ Cell Phone: ______________
Address: ______________________________
Business Phone: ______________ Home Phone: ______________

Name: ______________________________
Relationship: ______________ Cell Phone: ______________
Address: ______________________________
Business Phone: ______________ Home Phone: ______________

Name: ______________________________
Relationship: ______________ Cell Phone: ______________
Address: ______________________________
Business Phone: ______________ Home Phone: ______________

☐ **I understand that my child will be permitted to leave SONCCA ONLY with those individuals listed above, all of whom are at least sixteen years of age.**

☐ **I also understand that if both parents have not signed the forms and are not listed on this page, they will not be allowed to pick-up their child.**

______________________________ ______________
Parent/Guardian Signature Date

______________________________ ______________
Parent/Guardian Signature Date

SONCCA SUMMER 2021
PROGRAM PHOTOGRAPH PERMISSION FORM

Child's Name: ____

☐ I give permission to SONCCA (Seymour-Oxford Nursery & Child Care Association, Inc.) to take and use photographs of my child participating in the SONCCA program for publicity and fund development purposes, some of which may be included on the SONCCA website.

☐ I do not give permission to SONCCA (Seymour-Oxford Nursery & Child Care Association, Inc.) to take and use photographs of my child participating in the SONCCA program for publicity and fund development purposes, or to be shown on the SONCCA website

I also understand that SONCCA does take pictures and/or video for internal purposes only, even if I do not give permission for SONCCA to use them for publicity and fund development purposes, or to be used on the website. They are only for administrative purposes and are deleted.

Parent/Guardian's Signature: ____

Date:____

SONCCA 2021
SUMMER GRANT INFORMATION QUESTIONNAIRE

It is through the receipt of grants that SONCCA is able to provide quality care for your child at reasonable tuition rates. The following information is requested from local, state, federal, and other funding sources as a grant submission and reporting requirement. Please note names are not required. This form will be removed from your child's file and placed in our Grant Statistics file to be used when grant applications are made. If you wish, you may remove it from the rest of the packet and send it to the office separately.

Please place a checkmark or fill in all blanks, as appropriate:

Town: ☐ Seymour ☐ Oxford

Child's age: ________ Gender: ________________ Grade as of September 2021: ____________

Child's heritage:

☐ Asian ☐ African-American ☐ Caucasian ☐ Hispanic ☐ Native American

☐ Other, Please write in: ____

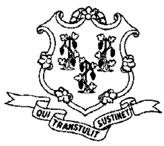
Family Size: __________ Number of Adults: __________ Number of Children: __________

Number of parents/guardians in the household: ________________

Number of parents/guardians working: ______________________ in training: ______________

Income:
☐ A: $23,850 - $32,913
☐ B: $32,913 - $47,700
☐ C: $47,700 - $71,500
☐ D: $71,500 - $110,000
☐ E: More than $110,00

Child is cared for by:
☐ Parent(s)
☐ A "supervising adult" (grandparents, foster parents, etc.)



State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name ____________________ Birth Date ____________ Date of Exam ____________

❑ I have reviewed the health history information provided in Part 1 of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made		
Genitalia/ hernia					
Skin					

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
History of Lead level ≥ 5μg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***Speech** (school entry only)	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis Allergies ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: ____________________
Daily Medications (*specify*): ____________________

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: ____________________

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: ____________

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) __________ __________ __________ __________ __________	❑ Yes ❑ No
Risk Assessment	**Describe Risk Factors**		
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other __________		❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other __________

Recommendation(s) by health care provider: ______________________________

____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child’s health and educational needs in school.

____

Signature of Parent/Guardian — Date

____

Signature of health care provider — DMD / DDS / MD / DO / APRN / PA / RDH — Date Signed — Printed/Stamped ***Provider*** Name and Phone Number

Student Name: ________________________ Birth Date: ______________ HAR-3 REV. 7/2018

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above ______________ (Specify) ______________ (Date) ______________ (Confirmed by)

Exemption: Religious ________ **Medical:** Permanent ________ Temporary ________ **Date:** ________

Renew Date: ________ ________ ________ ________

Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.
Medical exemptions that are temporary in nature must be renewed annually.

Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See “HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES” column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See “HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES” column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number