BROOKFIELD PUBLIC SCHOOL DISTRICT

100 Pocono Road, Brookfield, CT 06804
203-775-7700
www.brookfieldps.org

Student Registration Part A

Student Legal Name (as it appears on birth certificate)
First **Middle** **Last**

Date of Birth (mm/dd/yyyy)	**Student Home Telephone#**	**Is this student a multiple?** Yes___ No__

Grade Level	**Gender** Male___ Female___ Non-binary (Used for students who do not identify exclusively as male or female) __	**Birth Gender** (as it appears on birth certificate) Male___ Female___

Residence Address of Student
Street **Apt.#** **City** **State** **Zip**

Mailing Address (If different than above)
Street **Apt. #** **City** **State** **Zip**

Ethnic Group and Race Categories

The federal government requires that both these questions be answered and provides only the following categories for ethnic group and race. If both questions are not answered, school personnel are required to make selections for both.

1. **Is this student Hispanic or Latino?**
   ___ No, not Hispanic or Latino
   ___ Yes, Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)
2. **What is the student's race (select all that apply**)
   ___ (I) American Indian or Alaska Native
   (A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.)
   ___ (A) Asian
   (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.)
   ___ (B) Black or African American
   (A person having origins in any of the black racial groups of Africa.)
   ___ (W) White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa)
   ___ (P) Native Hawaiian / Other Pac Islander
   (A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.)

If born in the U.S.
Birth City __________________
Birth State __________________

Birth Place
In any of the 50 US States ___
Commonwealth of Puerto Rico ___
District of Columbia ___
Other ___

If OTHER :
List Country_____________________

Has the student completed 3 years of schooling in the US? Yes___ No____

Entry Date into US School __________

Entry Date in US _________________

Has this student ever been retained?
Yes___ No___
If yes, what grade___

Is this student a U.S. Citizen?
Yes____ No____

Does this student receive any of the following services?
Yes__No__
(check all that apply)
Special Education___ 504 Plan___ EL___ Other___
If other, please explain

If ANY are checked, a copy of the current PLAN and/or IEP are required before registration is complete.

Has this student ever attended BPS?
Yes__No___
Name of School **Grade** **Year**

Has this student ever been suspended or expelled?
Yes__ No__
If yes, what grade____

LIST SCHOOLS PREVIOUSLY ATTENDED

Name of School:____
Address:____
Start Date (month/day/year):__________ End Date (month/day/year):___________ Public __ NonPublic __

Name of School:____
Address:____
Start Date (month/day/year):__________ End Date (month/day/year):___________ Public __ NonPublic __

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Student Registration Part B

Student Legal Name ____

SIBLING INFORMATION - Please list all of the student's siblings.

Name_____________________________________ Grade ___ Name___________________________________ Grade ___

Name_____________________________________ Grade ___ Name___________________________________ Grade ___

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN 1
Name____ Relationship_________________

Email____ Phone#______________________

Address____
Street City State Zip
Contact Allowed - Yes__No__ Legal Guardian -Yes__ No__ Lives with- Yes__No__

PARENT/GUARDIAN 2
Name____ Relationship________________

Email____ Phone#______________________

Address____
Street City State Zip
Contact Allowed - Yes__No__ Legal Guardian -Yes__ No__ Lives with- Yes__No__

Student Resides With (check all that apply)	**Migrant Status**	**Homeless:**
Mother____ Father____ Both Parents ___ Legal Guardian____ Step Father___ Step Mother ___ Other____	This student and family has moved within the past 36 months across state or district boundaries to obtain temporary/seasonal employment? Yes__ No__	Not Homeless __ Hotel/Motel __ Shelter __ Double Up __ Unsheltered __

Military Status
Student's parent or guardian is a member of the Armed Forces on active duty or serves on full-time National Guard duty. Yes__ No__

Should the school be aware of any Court Order for the protection of your student? Yes___ No____
If yes, please make arrangements to meet with the school administration and provide custodial documentation to your student's school.

NOTE: A current legal court document must be provided to ensure compliance with custody orders.

Please inform your student's school of changes in custodial arrangements.

Additional Comments:
Enter any other comments or facts that might help with your student's placement. ____

____

The information within this student registration packet is true and correct to the best of my knowledge and belief.

____ _________________
Registering Parent Signature Date

For Office Use Only: Date of new entry ________________ Proof of Residency:___ Homeless :___ Entry Grade Level:___
Birth Certificate: ____ Date records requested: _____________ Health Forms___ Language Survey___ Transportation:___
Contact Restriction Yes___No___ District ID #: _____________ State ID #:________________
Parent Correspondence Language____

*Today's Date:*______________ *BPS Staff Registrar Signature*____

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For Office Use Only

_______ Bus In #

_______ Bus Out #

_______ Student #

BUS INFORMATION

Date____

Student's Name ____

Student's Address ____

Student's Grade _______ Home Phone#______________ M ___ F___

My student should be picked up at ____
Address

My student should be dropped off at ____
Address

Additional Information ____

____

________________________ ________________________
Parent's Name Phone Number

________________________ ________________________
Parent's Signature Date

CENTER ELEMENTARY SCHOOL—ONLY

Center Elementary School children must be met by an adult at the bus stop or the student will be brought back to school for your immediate pickup.

Children are not allowed to change buses or bus stops. Please include the names and phone numbers below of any adult, other than parents, who may be meeting the student at the bus stop.

___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________

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Acceptable Use Policy (AUP) for Student Google Apps Accounts
STUDENT CONTRACT

This form must be completed for students enrolling in Grades 2 – 12

I understand that use of the school account, including email, is viewed as a privilege and, as such, access may be used for educational and research purposes only. I realize misuse may result in school disciplinary action and in loss of privileges. I will abide by the Terms of Use set forth by Google and all Brookfield School District (BSD) policies.

With this school account, I will:

•Use the account only for my schoolwork,
•Keep my personal information private,
•Use appropriate language,
•Participate only in what my teacher allows me to do,
•Use web sites that help me with my work,
•Follow the rules of the school district's appropriate use policy,

Students who violate Brookfield Public Schools' policies with regard to acceptable use of student accounts and email will be subject to disciplinary action as determined to be appropriate by the administration and/or teacher.

Google Apps may be accessed via any Internet-enabled computer or device and parents are welcome and encouraged to participate in educating their children in safe, proper, and ethical use of the account including email communications.

I understand that inappropriate behavior will lead to disciplinary action.

I , ________________________________have read the above guidelines and agree to abide by them.
(Print student first and last name)

STUDENT SIGNATURE:

Signed: ____

Date: ____________________________

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STUDENT RECORDS RELEASE FORM

I hereby give my permission for my child's school records to be released to the Brookfield Public School District.

_______________________________________ ____________________
(Please Print) Parent/Guardian Date

_______________________________________ ____________________
Parent/Guardian's Signature Parent Phone Number

_______________________________________ _____/_____/______
Name of Student Date of Birth

Sending School: _______________________________ __________
(Name of Last School Student Attended) Last Grade Level Completed

____
(Address) City State Zip Code

(_____) ______________________ (______) ____________________
Phone Fax

Please include all items checked below.

___Academic Record (Report Card/Transcript/Withdrawal Grades)	___ 504
___Individual Education Programs	___ Health Record
___Speech /Hearing/Language Evaluations	___ Educational Evaluations
___Other Pertinent and/or Confidential Information	___ Psychological Evaluations
___Testing Scores (Standardized or Special Education)	___ Special Education File
___Discipline Records	
___ESL placement/exit info;LAS Scores(or WIDA);ESL Screening/Proficiency Level	

Please send information to selected school.

___ **Center Elementary School** 8 Obtuse Hill Road Brookfield, CT 06804 203-775-7650 (fax)203-775-7672	___ **Huckleberry Hill Elementary School** 100 Candlewood Lake Road Brookfield, CT 06804 203-775-7675 (fax)203-775-7684
___ **Whisconier Middle School** 17 West Whisconier Rd Brookfield, CT 06804 203-775-7710 (fax)203-775-7615	___ **Brookfield High School** 45 Longmeadow Hill Road Brookfield, CT 06804 203- 775-7725 (fax)203-775-7757

Thank you for your cooperation in this regard. It is greatly appreciated.

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WMS GUIDANCE SURVEY

This form MUST be completed for students enrolling in Grades 5-8

Student Name: ______________________________ **Entering Grade:** _______________

The following information will assist us in placing your child into the appropriate courses:

Math Placement:

________ On Grade Level
________ Above Grade Level
________ Below Grade Level
________ Remedial or Self-Contained

_______ Completed Pre-Algebra
_______ Completed Algebra
_______ Other:

World Language: World Language begins in 5th grade at the middle school with Spanish.
Beginning in 7th grade, you can choose between French or Spanish.

Language of choice for 7th/8th grade: _____ French _____ Spanish

Previous Study:

______ Spanish Years of Study: _______ Level: _________ Middle School
______ French Years of Study _______ _________ Advanced Level (high school)

Other Concerns: Please note any other concerns or needs (such as health needs, behavioral concerns, academic responsibility, family issues), which would assist us in meeting your child's needs.

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TUBERCULOSIS RISK QUESTIONNAIRE

Date:______________________
Last Name: ____________________________ First Name:_______________________ Middle Name:______________
Date of Birth:__________________ Grade__________________

Please check below:

________One or more of the listed Tuberculosis risk factors applies to my child*

________None of the listed Tuberculosis risk factors apply to my child

Parent/Guardian Signature______________________________ Date__________________

- ☐ Recent or prolonged contact with someone who has infectious TB or positive TB skin test
- ☐ Born in a high-prevalence TB area (Africa, Asia, including the former Soviet Union and India, Central and South America, Eastern Europe, Mexico, Haiti, Philippines or the Dominican Republic)
- ☐ Travel outside the US to a high-prevalence TB area (Africa, Asia, including the former Soviet Union and India, Central and South America, Eastern Europe, Mexico, Haiti, Philippines or the Dominican Republic)
- ☐ Exposure to a person who has been in jail, has HIV, is homeless, lives in a group home or shelter, uses illegal drugs or is a migrant farm worker
- ☐ Has a health problem that lowers the immune system
- ☐ Has a household member who was born in or has traveled to a high-prevalence TB area
- ☐ Has symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray
- ☐ Has drunk raw milk or eaten unpasteurized cheese since last TB skin test

*Any student identified as to having one or more TB risk factors will be required to have a TB skin test placed and read before school entry. A history of BCG vaccination is not a contraindication to testing nor should it be considered in interpretation of the skin test result. A positive reaction to the TB skin test requires a letter from a physician stating that a chest x-ray has been done and the child is free of active TB.

BROOKFIELD PUBLIC SCHOOLS
BROOKFIELD, CT 06804

STUDENT HEALTH HISTORY

Student's Last name	First	Middle	Gender	Birth date	Grade

Please complete all the items below by marking the yes or no box. If an item is marked yes, indicate the date(s) of the occurrence. Space is provided for any additional comments you may have relative to health issues.

A. CHILDHOOD ILLNESSES	YES	NO	DATE(S)
Lyme Disease			
Meningitis			
Rheumatic Fever			
Varicella/Chickenpox			
B. SEVERE ALLERGIES (Explain below)			
Bee Sting			
Food			
Drug			
Epi-pen required			
Benadryl required			
C. CARDIOVASCULAR			
History of heart disease			
Surgical Procedures			
D. EARS, NOSE and THROAT			
Hearing impairment			
More than 2 ear infections/year			
Ear tubes			
Frequent nosebleeds			
More than 2 throat infections/year and/or strep			
E. EYES			
History of eye problems			
Glasses/contacts for reading/distance			
F. GASTROINTESTINAL			
Frequent stomachaches/constipation/diarrhea			
Food sensitivity or intolerance (Explain below)			
G. NEUROMUSCULAR			
History of neuromuscular condition			
History of seizure disorder			

H. RESPIRATORY	YES	NO	DATE(S)
Asthma			
Inhaler required in school			
Wheezing or difficulty breathing with exercise			
Frequent colds/cough			
Pneumonia/bronchitis			
I. SKELETAL			
Broken bones			
History of scoliosis			
J. SKIN			
Eczema			
Hives or rashes			
K. URINARY			
History of urinary infection			
History of urinary tract condition			
L. SPECIAL CONSIDERATIONS			
Diabetes			
Other chronic condition			
Under the care of a specialist			
Special Needs (OT,PT, bracing)			
Physical Restriction			
Medication on a regular basis			
Medical/Religious Exemption			
M. HOSPITALIZATIONS			
Include reasons under comments			

COMMENTS

Continue on back if necessary

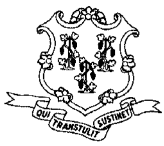
In case of serious injury or illness at school, your child will be sent to an emergency medical facility. The parent/guardian will be contacted immediately and is responsible for all expenses.

Physician's Name: ____ Telephone: ________________

Dentist's Name: ____ Telephone: ________________

____ ____________
Parent/Guardian Signature Date

3/2013



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	❑ Pass
	❑ Fail	❑ 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