Immunization Requirements
for
Kindergarten and Preschool Students

D.P.T.

A minimum of four (4) doses of diphtheria and pertussis vaccine and tetanus toxoid, one (1) dose of which shall have been given on or after the fourth (4^{th}) birthday.

POLIO

A minimum of three (3) doses of IPV or oral poliovirus (ORAL TRIVALENT) vaccine, one (1) does of which shall have been given on or after the fourth (4^{th}) birthday.

MUMPS, MEASLES, GERMAN MEASLES (RUBELLA)

A minimum of two (2) doses of a measles-containing vaccine given on or after the first (1^{st}) birthday, preferably MMR. (The two doses must be separated by an interval of at least one month).

HEPATITIS B

Three (3) doses of Hepatitis B vaccine or any vaccine combination containing hepatitis B virus.

VARICELLA

One (1) dose on or after first (1^{st}) birthday, or written proof of immunity.

ALSO REQUIRED FOR PRESCHOOL STUDENTS:

Pneumoccal (bacterial) pneumonia vaccine - Ages 8 weeks to 4 years, 9 months.

Annual Influenza Vaccine – Ages 6 months to 4 years, 9 months.

Hib (Haemophilis B) – Mandated only for children enrolled in childcare, preschool or pre-kindergarten. (DPT/Hib and Hib/HepB also valid Hib doses)

If an immunization is withheld for medical reasons, a medical contraindication form, signed by the physician, must accompany the immunization record.

KINDERGARTEN PHYSICAL EXAMINATION REPORT

We in the schools are vitally interested, as you are, in the health of your child. Best results are obtained when the home and school work together in establishing sound health practices and attitudes. The health of your child is of major importance in his/her educational achievement. For this reason we ask you to provide the following information which will give us a much needed foundation upon which to begin his/her education here at school.

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CHILD'S NAME _____ **SEX** _____ **BIRTHDATE** _____

FATHER'S NAME _____ **MOTHER'S NAME** _____

BROTHERS/SISTERS (names/ages) _____

DATE OF PHYSICAL _____

PULSE _____ **RESP.** _____ **B/P** _____ **HEIGHT** _____ **WEIGHT** _____

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TO BE COMPLETED BY PHYSICIAN

	YES/DATE	NO	DISEASE HISTORY	YES/DATE	NO
EYES, LIDS			CHICKEN POX		
EARS			MEASLES		
NOSE, THROAT			MUMPS		
LUNGS			RHEUMATIC FEVER		
HEART			EPILEPSY		
NUTRITION			NEUROLOGICAL EXAM		
ORTHOPEDIC			SCARLET FEVER		
SKIN, SCALP			STREP THROAT		
CHRONIC CONDITIONS			GERMAN MEASLES		
			PSYCHOLOGICAL EXAM		
VISION (SPECIFY TEST):					
HEARING (SPECIFY TEST):					

ALLERGIES THAT MIGHT AFFECT SCHOOL BEHAVIOR OR SCHOOL ATTENDANCE _____

_____

PLEASE REPORT ANY PHYSICAL CONDITION THAT MAY AFFECT CHILD'S PARTICIPATION IN A NORMAL SCHOOL PROGRAM _____

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IMMUNIZATION RECORD - ALL REQUIRED-PLEASE ATTACH

D.P.T. DATES: 1._____ 2._____ 3._____ 4._____ 5._____

POLIO IMMUNIZATION: 1._____ 2._____ 3._____ 4._____

MEASLES/MUMPS/RUBELLA (MMR) VACCINE: 1._____ 2._____

VARIVAX _____

HepB: 1._____ 2._____ 3. _____

COMPLETE ONLY IF CHILD RECEVIED SAME:

MANTOUX TEST: TESTED:_____ READ:_____ RESULTS _____

HIB: 1._____ 2._____ 3. _____ OTHER _____

PNEUMOCCAL: 1. _____ 2. _____ 3. _____ 4. _____

INFLUENZA: 1. _____ HEPA: 1. _____ 2. _____

_____ _____

EXAMINING DOCTOR'S SIGNATURE / PRINT NAME / STAMP (required) **DATE**