TOWN OF FAIRFIELD
SCHOOL HEALTH PROGRAM

To: Parents of Pre-school students
From: School Nurse

According to Connecticut State General Statute Section 10-204a, all individuals who are enrolled in pre-school, and are between the ages of 24 months and 59 months, must receive adequate immunization to Influenza.

To be considered in compliance with that requirement, the following shall be completed:

For students previously vaccinated for flu:

- One dose of influenza vaccine administered between August 1st, 2019 and December 31st, 2019.

For students not vaccinated for flu anytime in the past:

- Two doses of influenza vaccine administered between August 1st, 2019 and December 31st, 2019 and separated by 28 days.
- Students will be permitted to enter school after the first dose of the series is administered.

Please provide documentation from your Health Care Provider of the above to your school nurse.

Students not in compliance will not be permitted to enter school on January 1, 2020.

Connecticut State statutes permit exemptions from receiving immunizations if vaccination is medically contraindicated and such contraindication is certified by a physician and is in accordance with the provisions of state law, ***or*** if such immunization is contrary to the religious beliefs of the child and there is parent/guardian statement to that effect. A written statement indicating same is required.

For further information, contact the school nurse.

Thank you for your cooperation in this important matter.

Town of Fairfield School Health Program

Name of Child: _____ DOB: _____

School:_____ _____

Your child requires the following immunizations:

Influenza dose # 1 _____ # 2 _____ (must be administered before January 1, 2020)

Please return the form below to your school nurse upon completion. Thank you.

I certify that_____has received the following immunization(s):
(Name of child)

Influenza dose # 1 _____ Date administered:_____ _____

Influenza dose # 2 _____ Date administered:_____

_____ _____
Signature of Health Care Provider Date

_____ _____
Name of Health Care Provider Phone Number
(Please type or print)