To: Parents, Caregivers and Guardians
Re: 2020-2021 International, Out-of-State Transfer and Incoming/Freshmen SMCHS Students

California schools are required by law to check the immunization records for all new student admissions. It is important to get your student vaccinated early so there will be no issue with school entry. (California Code of Regulations Title 17, Division 1, Chapter 4.)

9th – 12th Admission	
Vaccine	**Number of Doses Required of Each Immunization**
3 Polio OPV or IPV	3 doses meet requirement if 1 dose was given on or after 4th birthday; if not, 4 doses are needed
1 Tdap Tetanus Toxoid, Reduced Diphtheria Toxoid & Acellular Pertussis **THIS IS A CALIFORNIA STATE REQUIREMENT**	1 dose of pertussis-containing vaccine is required on or after 7th birthday Tdap will meet (1) DTaP requirement *Students will not be allowed to attend school without documentation of a Tdap immunization*
3 DTaP, DTP Diphtheria, Tetanus, & Pertussis **Td** Tetanus	3 doses meet requirement if **Tdap** was given on or after 7th birthday 1-2 doses of Td given on or after 7th birthday count towards the requirement
3 Hep B Hepatitis B	
2 MMR Measles, Mumps & Rubella	only doses given on or after 1st birthday meet the requirement
2 Varicella Chickenpox	OR Chicken Pox disease history with **Permanent Medical Exemption** documentation by a California physician will meet the requirement
Titers: Serum titers are blood tests that measure whether or not you are immune to a given disease(s). Positive titers will require a **Permanent Medical Exemption** issued by a physician.	

Additional information is available at www.ShotsForSchool.org or contact the SMCHS Nurses Office at deptofnursing@smhs.org

Sincerely,

Lisa Volpo RN, BSN and Rebecca Wood RN, BSN
School Nurse – Health and Wellness Office
Santa Margarita Catholic High School

TRANSFER & INTERNATIONAL STUDENT IMMUNIZATION RECORD '20 -'21

This record must be completed by a physician from an immunization record provided by a parent or guardian. Dates must include the month, day and year.

Student Name____ Grad Yr__________ Sex: M ☐ F ☐ Birthdate (MM/DD/YYYY) _______________________

Name of Parent/Guardian ____ Race/Ethnicity: ____

Record presented was: _____ Yellow CA Immunization Record _____ CSIR _____ Out-of-State School Record ____ MD translated Record ____Other Immunization Record

California Dept of Public Health / ShotsForSchool.org	Date each dose given				
	1st	2nd	3rd	4th	5th
REQUIRED IMMUNIZATIONS FOR 9TH-12TH GRADE	**MM/DD/YYYY**	**MM/DD/YYYY**	**MM/DD/YYYY**	**MM/DD/YYYY**	**MM/DD/YYYY**
Polio OPV or IPV **3 doses** meet requirement if one dose was given on or after the 4th birthday. If not, 4 doses are needed	___/___/_____	___/___/_____	___/___/_____ Age ________ years	___/___/_____	
DTP/DTaP Diphtheria, Tetanus, & Pertussis **3 doses** meet requirement if **Tdap** was given on or after 7th birthday ***Td** Tetanus 1-2 doses given on or after 7th birthday count towards the requirement	___/___/_____	___/___/_____	___/___/_____ Age ________ years	___/___/_____ Age ________ years	___/___/_____
Tdap/Boostrix/Adacel Tetanus Toxoid, Reduced Diphtheria Toxoid & Acellular Pertussis **1 dose on or after 7th birthday**. Tdap will meet DTaP requirement	___/___/_____ Age ________ years	**THIS IS A CALIFORNIA STATE REQUIREMENT**			
HEP B (Hepatitis B) **3 doses**	___/___/_____	___/___/_____	___/___/_____		
MMR combined immunization for Measles, Mumps & Rubella **2 doses** (on or after 1st birthday)	___/___/_____ Age ________ years	___/___/_____ Age ________ years			
***OR** doses given separately for Measles, Mumps & Rubella list below:* **Measles** Rubella – 10 day Measles **2 doses** (on or after 1st birthday)	___/___/_____	___/___/_____			
Mumps **2 doses** (on or after 1st birthday)	___/___/_____	___/___/_____			
Rubella German Measles – 3 day Measles **1 dose** (on or after 1st birthday)	___/___/_____	___/___/_____			
Varicella (Chickenpox) **2 doses**	___/___/_____	___/___/_____	Varicella disease history or titer with a **Permanent Medical Exemption** documented by a California licensed physician will meet the requirement		

PHYSICIAN'S NAME (please type or print):	PHYSICIAN'S SIGNATURE:	DATE:	PHYSICIAN'S STAMP/SEAL (REQUIRED):
ADDRESS:	PHONE:		

OVER ⇨

OTHER IMMUNIZATIONS (NOT REQUIRED)

TRANSFER & INTERNATIONAL STUDENT IMMUNIZATION RECORD

This record must be completed by a physician from an immunization record provided by a parent or guardian. Dates must include the month, day and year.

Student Name____ Sex: M F Birthdate (MM/DD/YYYY) _____________________________

VACCINE	Date each dose given				
	1st MM/DD/YYYY	2nd MM/DD/YYYY	3rd MM/DD/YYYY	4th MM/DD/YYYY	5th MM/DD/YYYY
Hepatitis A	___/___/_____	___/___/_____			
Hib (Haemophilus influenza type b)	___/___/_____	___/___/_____	___/___/_____	___/___/_____	
Meningococcal / Meningitis 1 dose recommended for college admission	___/___/_____	___/___/_____	___/___/_____	___/___/_____	___/___/_____
Pneumococcal	___/___/_____	___/___/_____	___/___/_____	___/___/_____	___/___/_____
HPV (Human Papillomavirus)	___/___/_____	___/___/_____	___/___/_____	___/___/_____	___/___/_____
Influenza	___/___/_____	___/___/_____	___/___/_____	___/___/_____	___/___/_____
Encephalitis B	___/___/_____	___/___/_____	___/___/_____	___/___/_____	___/___/_____
JE (Japanese Encephalitis)	___/___/_____	___/___/_____	___/___/_____	___/___/_____	___/___/_____
BCG Tuberculosis vaccine	___/___/_____	___/___/_____			
PPD-Mantoux Tuberculosis Testing (most recent)	___/___/_______	Positive ☐ Negative ☐	CXR ___/___/___ Normal ☐ Abnormal ☐		
Other	___/___/_____	___/___/_____	___/___/_____	___/___/_____	___/___/_____

PHYSICIAN'S NAME (please type or print):	PHYSICIAN'S SIGNATURE:	DATE:	PHYSICIAN'S STAMP/SEAL (REQUIRED):
ADDRESS:	PHONE:		