

2022-2023 California School Immunization Requirements 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 4 th 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 7 th birthday. Tdap will meet (1) DTaP requirement. <i>Students will not be allowed to attend school without documentation of a Tdap immunization.</i>
3 DTaP, DTP Diphtheria, Tetanus, & Pertussis Td Tetanus	3 doses meet requirement if Tdap was given on or after 7 th birthday. 1-2 doses of Td given on or after 7 th birthday count towards the requirement.
3 Hep B Hepatitis B	3 doses at any age meets requirement
2 MMR Measles, Mumps & Rubella	only doses given on or after 1 st birthday meet the requirement
2 Varicella Chickenpox	"History of chickenpox disease" does not meet the chickenpox immunization requirement. A medical exemption issued using CAIR-ME may be used for a child who had chickenpox disease that was documented by a physician (see below)

There is no requirement for a COVID-19 vaccine for the 2022-2023 school year.

- Since January 1, 2016, **Personal Beliefs Exemptions** for currently-required vaccines are no longer allowed in any school, whether public or private.
- **Medical Exemptions for Required Immunizations** - Starting January 1, 2021, all new medical exemptions for school entry must be issued through the California Immunization Registry – Medical Exemption website CAIR-ME <https://cair.cdph.ca.gov/exemptions/home>. Parents and physicians can register and create an account in CAIR-ME at any time. Once registered, parents can log in to CAIR-ME to request a medical exemption. Parents take the exemption request number to their child's physician who can log in to CAIR-ME to issue the exemption. Once the exemption is issued, the physician prints the two-page form and provides a copy to the parents to give to their child's school.
- **Existing Medical exemptions issued before 2021** will remain on file at schools and do not need to be uploaded into CAIR-ME.
- **Existing Medical exemptions in CAIR-ME** can be accepted, but parents must update the school information listed in CAIR-ME for the exemption and provide a copy to the school.
- **Medical exemptions issued before January 1, 2020 by physicians who have been disciplined by their medical licensing board** were no longer valid after the beginning of the 2021-2022 school year. To find out if a physician has been disciplined by the Medical Board or Osteopathic Medical Board, please look up an issuing physician's name or medical license number on the [list of disciplined physicians](#).

8/2022

For more information about immunization requirements and medical exemptions please visit:
<https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/School/shotsforschool.aspx>

TRANSFER & INTERNATIONAL STUDENT IMMUNIZATION RECORD '22 -'23

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 REQUIRED IMMUNIZATIONS FOR 9TH-12TH GRADE	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose
	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 4 th 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 7 th birthday *Td Tetanus 1-2 doses given on or after 7 th 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 1 st birthday)	_/_/____ Age _____ years	_/_/____ Age _____ years			
<i>OR doses given separately for Measles, Mumps & Rubella list below:</i> Measles Rubella – 10 day Measles 2 doses (on or after 1 st birthday)	_/_/____	_/_/____			
Mumps 2 doses (on or after 1 st birthday)	_/_/____	_/_/____			
Rubella German Measles – 3 day Measles 1 dose (on or after 1 st birthday)	_/_/____	_/_/____			
Varicella (Chickenpox) 2 doses	_/_/____	_/_/____			
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 '22 – '23

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	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose
	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Hepatitis A	_/_/___	_/_/___			
Hib (Haemophilus influenza type b)	_/_/___	_/_/___	_/_/___	_/_/___	
Meningococcal / Meningitis 1 dose <u>recommended</u> for college admission	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___
Pneumococcal	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___
HPV (Human Papillomavirus)	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___
Influenza	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___
COVID-19 Vaccine Type: _____	_/_/___	_/_/___			
COVID-19 Booster Type: _____	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___
BCG Tuberculosis vaccine	_/_/___	_/_/___			
PPD-Mantoux Tuberculosis Testing (most recent)	_/_/___	Positive <input type="checkbox"/> Normal <input type="checkbox"/> Negative <input type="checkbox"/> CXR <input type="checkbox"/> Abnormal <input type="checkbox"/>			
Other	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___
PHYSICIAN'S NAME (please type or print):	PHYSICIAN'S SIGNATURE:		DATE:	PHYSICIAN'S STAMP/SEAL (REQUIRED):	
ADDRESS:	PHONE:				