



## **Early Childhood Education ~ Immunization Requirements**

Effective September 1, 2016, SB 792 required anyone employed, substituting or volunteering who provides “care and supervision” at child care centers, including the programs of Head Start and State Preschool, will adhere to specific immunization requirements.

All current employees are required to provide verification of current immunizations for Pertussis/Whooping Cough, Measles and Influenza (flu). Attached are two forms to be completed by your physicians. The first verifies your current immunization for Measles and Pertussis or provides an explanation of why your physician recommends you not receive the vaccines. The second is a combination verification of flu immunization or your declination to receive the flu vaccine. The influenza vaccine is the only vaccine that you have the option to decline. Again, if your physician recommends that you do not receive the vaccination, they must complete the form indicating the reason.

The cost for these vaccinations should be covered by your insurance under “The Affordable Care Act,” however if costs are incurred for completion of the form or immunizations, you may submit for reimbursement by the district with your verification of current immunizations.

It is important to note per SB 792, failure to comply with the above immunization requirements will deem an employee, substitute and volunteer ineligible and unqualified for their job/position.



Patient/Employee name: \_\_\_\_\_ DOB \_\_\_\_\_

Patient/Employee signature: \_\_\_\_\_

Senate Bill 792 was approved by the Governor and requires employees, substitutes and volunteers to be vaccinated against or immune to influenza (flu) annually between August 1<sup>st</sup> and December 1<sup>st</sup> or to decline vaccination against influenza (flu).

**DECLINATION**

I, \_\_\_\_\_, hereby decline to be vaccinated against influenza (flu).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ School Year: \_\_\_\_\_

**OR**

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**PLEASE HAVE YOUR HEALTH PROFESSIONAL COMPLETE THE SECTION BELOW.**

The health professional listed below has cleared me as follows:

**Influenza**

Currently Immunized: Date \_\_\_\_\_

Vaccine Not Recommended  
Reason: \_\_\_\_\_

Health Professional' Signature: \_\_\_\_\_

Date of Clearance: \_\_\_\_\_

Health Professional's Name: \_\_\_\_\_

Health Professional's Phone Number: \_\_\_\_\_



Patient/Employee name: \_\_\_\_\_ DOB \_\_\_\_\_

Patient/Employee signature: \_\_\_\_\_

Senate Bill 792 was approved by the Governor and requires employees, substitutes and volunteers to be vaccinated against measles and pertussis (whooping cough).

**PLEASE HAVE YOUR HEALTH PROFESSIONAL COMPLETE THE SECTION BELOW.**

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The physician listed below certifies my vaccination or immunity as follows:

Measles (MMR)

Pertussis/Whooping Cough (TDaP)

Currently Immunized  
Date (mm/dd/yy); \_\_\_\_\_

Currently Immunized  
Date (mm/dd/yy): \_\_\_\_\_

Vaccine Not Recommended  
Reason: \_\_\_\_\_  
\_\_\_\_\_

Vaccine Not Recommended  
Reason: \_\_\_\_\_  
\_\_\_\_\_

Adults born prior to 1957 are generally  
Considered immune

Proof of Immunity (Titers Blood Test)

Health Professional' Signature: \_\_\_\_\_

Date of Clearance: \_\_\_\_\_

Health Professional's Name: \_\_\_\_\_

Health Professional's Phone Number: \_\_\_\_\_