Edmonds School District

P-135
Student Residency Verification Form

Verification of Residency Statement

Student Name: _____ School: _____ Grade:_____

Address: _____ City: _____ State: _____ Zip: _____

In order to verify residency within the district, ONE current documentation from the following list MUST be provided. The document must be dated within the last sixty days showing parent/guardian name and address (P.O. Box numbers are not acceptable as a residential address).

- ❑ Escrow papers, mortgage book or statement
- ❑ Residence insurance statement
- ❑ Lease/Rental Agreement with current rent receipt
- ❑ Gas bill or electric bill
- ❑ Water Bill
- ❑ Cable TV and internet bill
- ❑ Garbage bill
- ❑ Phone bill for a land line at the stated address
- ❑ Other documents approved by school: _____
- ❑ If you are part of the **Washington State Address Confidentiality Program**, official documentation from the Address Confidentiality Program stating the attendance area school fulfills the requirement to establish residency in the Edmonds School District. You must submit a renewed letter to the school each year.
- ❑ Verification of living with _____. **Must complete the P-110 Affidavit of Residency Form**, available upon request at the school.

If you are unable to provide any of the above items, please contact the school to discuss your circumstances and discuss next steps.

Please list below the names of additional student at this address who attends a school in the Edmonds School District.

Student: _____ School: _____ Date of Birth _____Grade_____

Student: _____ School: _____ Date of Birth _____Grade_____

Student: _____ School: _____ Date of Birth _____Grade_____

I declare that the above named student(s) reside at the address shown on one of the documents indicated above and attached to this enrollment packet. I will notify the school within two weeks of residency changes and agree to provide a new proof of residency and updated signed statement at that time. If I move outside of the school district boundaries, **I understand a Choice Transfer Application must be filed and approved in order to continue attendance at the school listed above, go to this link https://eds.ospi.k12.wa.us/ChoicetransferRequest.**

Falsification of any information or document required for residency verification, or the use of the address of another person without actually residing there, may result in revocation of student's enrollment in the Edmonds School District (see Policy 3131).

Parent/Guardian Printed Name: _____ Parent/Guardian Email:_____

Parent/Guardian Signature: _____ Date: _____

For Office Use Only: Current Student – Recently Moved has NEW Address

Student(s) Request:

Transfer to new school assigned to address: ❑ Immediately or ❑ Date: _____

Continue to attend current school through Grade 6____ Grade 8 ____ Grade 12 ____
(Students not approved to remain in path, must apply for school change when changing schools)

School: Email a copy of this form to SchoolChange@edmonds.wednet.edu

Original placed in cumulative folder with new proof of residency attached

Rev 1/24

Edmonds School District

P-160
Student Housing Questionnaire

Complete this form ONLY IF your housing situation is transitional or unstable.
If you own, rent, or lease your home, please DO NOT complete this form.

The answers to the following questions can help determine the services this student may be eligible to receive under the McKinney-Vento Act 42 U.S.C. 11435. The McKinney-Vento Act provides services and supports for children and youth experiencing homelessness. (Please see reverse side for more information.)

If the student lives in a home owned or rented by the parent or guardian, you do no need to complete this form unless there are inadequate facilities (no water, heat, electricity, etc.). If you do not own/rent your own home, please check all that apply below.

- ❍ In a motel/hotel
- ❍ In a shelter (short term/long term)
- ❍ Moving from place to place/couch surfing
- ❍ In someone else's house or apartment with another family
- ❍ In a residence with inadequate facilities (no water, heat, electricity, etc.)
- ❍ A car, park, campsite, or similar location
- ❍ Transitional Housing
- ❍ Other _____

Name of Student (Last, First)	School	Grade	Birthdate	Age

Additional student(s): _____

❍ Student is unaccompanied (not living with a parent or legal guardian)
❍ Student is living with a parent or legal guardian
❍ Student is in foster care

ADDRESS OF CURRENT RESIDENCE: _____

Does the student need transportation to/from school: ❍ Yes ❍ No

PHONE NUMBER OR CONTACT NUMBER: _____ NAME OF CONTACT: _____

Print name of parent(s)/legal guardian(s): _____
(Or unaccompanied youth)

*Signature of parent/legal guardian: _____ Date: _____
(Or unaccompanied youth)

❍ The student(s) named above have younger siblings/children (not yet school age) who need developmental screening, community support, or referrals to early childhood services.

Please return completed form to your school. School will scan info to the District Homeless Liaison

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For District Homeless Liaison Only: For data collection purposes and student information system coding

❍ (N) Not Homeless ❍ (A) Shelters ❍ (B) Doubled-Up
❍ (C) Unsheltered ❍ (D) Hotels/Motels ❍ (E) Unaccompanied Youth

McKinney-Vento Act 42 U.S.C. 11435
SEC. 725. DEFINITIONS.

For purposes of this subtitle:

(1) The terms enroll' and enrollment' include attending classes and participating fully in school activities.

(2) The term homeless children and youths' —

(A) means individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1)); and

(B) includes —

(i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals;

(ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C));

(iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

(6) The term unaccompanied youth' includes a youth not in the physical custody of a parent or guardian.

Additional Resources

Parent information and resources can be found at the following:

http://center.serve.org/nche/ibt/parent_res.php
http://www.schoolhouseconnection.org/
https://www.k12.wa.us/student-success/access-opportunity-education/students-experiencing-homelessness/mckinney-vento-act

Edmonds School District

HS-534
Student Health Enrollment Letter

Serving Brier, Edmonds, Lynnwood, Mountlake Terrace, Woodway, and portions of Snohomish County

The purpose of sending this letter is to gather information about students who have health needs. Please fill out the form, "Student Health Registration - HS 534," whether or not your student has medical needs that might require daily or emergency care to keep them healthy and safe. As parents/guardians it is important to be aware of what is required by law before your student can start school.

Chronic Health Conditions

- If your child has a life threatening condition that will put the student in danger of death during the school day if a medication or treatment is not in place; please notify the school nurse.
- Students with at-risk conditions are required to have medication and a treatment order from a licensed health care provider and a school care plan in place before they start school.
- Provide necessary changes that occur during the school year, either with contact numbers or your student's health condition (per RCW 28.A.210.320).

Medication Administration

- Medication must be sent in the original container if it is an over the counter medicine.
- If is a prescribed medication, the bottle must be properly labeled and be in the original container.
- Please check expiration dates. School personnel are not allowed to give expired medications.
- A medication consent form is required for any medication given at school. **Signatures from a parent/guardian AND the student's health care provider are required for ANY medication to be given at school. This includes prescription as well as over the counter medications.**
- Faxed consents from parents and/or doctors are acceptable.

The Edmonds medication policy may be viewed on the Edmonds School District website under School Board Policies and Procedures.

If you have questions or concerns, please contact the school nurse.

Sincerely,
Health Services Team

Student Services
Educational Services Center | 20420 68th Ave. W. | Lynnwood, WA 98036
www.edmonds.wednet.edu

Edmonds School District

HS-534
Student Health Enrollment

School: _____ Expected Start Date: _____

Student Name	Date of Birth	Gender	Gender Preferred	Grade
Parent/Guardian Name	Phone	Email		
Healthcare Provider Name Phone		Dentist Name Phone		

ALERT: The school must know of **LIFE THREATENING** conditions (such as severe allergies, asthma, diabetes, seizures, or other at-risk conditions). This requires a Life-Threatening Emergency Care Plan and any necessary medication, supplies, and provider orders to be in place before your student can attend school (per RCW 28A. 210.320).

Medical History - Signature required on page 2

Health Insurance ❑ Yes ❑ No

❑ **NO KNOWN CONDITION**

Life-Threatening Conditions: Care plan is required

- **EG** ❑ **Anaphylaxis (Epi-pen prescribed)**
- **EK** ❑ **Diabetes Type 1**
- **NP** ❑ **Seizures (Emergency medication required)**
- **RG** ❑ **Asthma - Severe**

Congenital / Genetic

- AH ❑ Down Syndrome
- AJ ❑ Fetal Alcohol Spectrum Disorder

Blood / Hematology

- BA ❑ Anemia
- BB ❑ Hemophilia
- BC ❑ Sickle Cell Disease Trait
- OJ ❑ History of Severe Nosebleeds

Cardiac / Heart

- CC ❑ Heart Birth Defect
- CD ❑ Heart Murmur

Allergy, Immune, Endocrine, Metabolic and Nutritional

- ED ❑ Allergy – Food
- EE ❑ Allergy- Insect
- ❑ Allergy Other
- EL ❑ Diabetes Type 2

Gastrointestinal, Dental and Oral

- GA ❑ Celiac
- GG ❑ Food Intolerance List:
- GL ❑ Lactose Intolerance
- GF ❑ Encopresis
- GO ❑ Chronic Constipation
- GH ❑ Gastric Reflux
- GJ ❑ Inflammatory Bowel Disease
- GK ❑ Irritable Bowel Syndrome
- ❑ Dental / Oral Condition

Musculoskeletal

- MC ❑ Juvenile Rheumatoid/ Idiopathic arthritis

Nervous System

- NB ❑ ADHD/ADD diagnosed
- NC ❑ Autism Spectrum Disorder
- NE ❑ Cerebral Palsy
- NF ❑ Developmental Disability
- NH ❑ Migraines
- NI ❑ Headaches, Recurring
- NP ❑ Seizure Disorder ❑ Current ❑ Historical
- NU ❑ Traumatic Brain Injury

Transplant

- OD ❑ List Organ:

Mental or Behavioral Health

- PA ❑ Anxiety
- PC ❑ Depression
- PH ❑ Sleep Disorder

Respiratory / Breathing

- RG ❑ Asthma – Current
- RH ❑ Asthma – Ever Diagnosed
- RA ❑ Asthma – Exercise Induced
- RE ❑ Reactive Airway Disease

Skin

- SB ❑ Eczema / Contact Dermatitis / Psoriasis

Renal / Kidney

Please List:_____

Ear / Hearing

- YA ❑ Chronic Ear Infection ❑ Current ❑ Historical
- YB ❑ Hearing Impaired – Hearing Aid(s) Cochlear Implant

EYE / Vision

- YF ❑ Wears glasses /contacts
- YE ❑ Color Vision Deficit
- YD ❑ Visually Impaired

OTHER CONDITIONS:_____

_____

Medication/treatments at School ❑ No ❑ Yes (requires written authorization signed by Health Care Provider)

❑ Complete required paperwork for medication at school

Medication at Home ❑ No ❑ Yes Please List: _____

ALLERGIES

What causes allergic reactions?_____

Date of most recent allergic reaction: _____

Allergic Reaction:

❑ Hives ❑ Swelling of lips, mouth, tongue, throat ❑ Difficulty breathing ❑ Nausea, stomach cramps, vomiting, diarrhea

Did this allergic reaction require emergency care? ❑ No ❑ Yes (Please explain)_____

Has your student had an allergy testing completed? ❑ No ❑ Yes (Where and when?)_____

Allergy Medications:

Name	Dose	Frequency

ASTHMA

What causes asthma symptoms? ❑ Respiratory Infection ❑ Pollens/Molds ❑ Exercise ❑ Weather /Temperature ❑ Animals ❑ Smoke ❑ Poor air quality ❑ Strong odors/Perfumes

Date of diagnoses: _____Health Care Provider who diagnosed student:_____

Asthma Medications:

Name	Dose	Frequency

Does your student use a spacer/aero chamber with their inhaler? ❑ No ❑ Yes

Has your student needed oral steroids (ie: prednisone)? ❑ No ❑ Yes (When?)_____

Has your student been to the hospital for asthma? ❑ No ❑ Yes (please Explain)_____

DIABETES

Date of diagnoses:_____ Medication ❑ Oral_____ ❑ Insulin (type)_____

Equipment ❑ Insulin pen ❑ Insulin pump (type)_____ ❑ CGM (type)_____

Can your student check their own BG (Blood Glucose) independently? ❑ No ❑ Yes

Can your student count carbs independently? ❑ No ❑ Yes

Can your student calculate their own insulin doses independently? ❑ No ❑ Yes

Can your student self-administer insulin independently? ❑ No ❑ Yes

SEIZURES

Date of first seizure:_____ Date of most recent seizure:_____

Frequency of seizure activity: ❑ Once ❑ Daily ❑ Weekly ❑ Monthly ❑ Yearly

Type of seizures:_____

Seizure Medications:

Name	Dose	Frequency

Has your student has a seizure that has required emergency care/medication? ❑ No ❑ Yes When?_____

Please explain: _____

Medical Devices	Stoma	Physical Activity/Mobility
OLA ❑ Vagal Nerve Stimulator	OKA ❑ Gastrostomy	❑ Wheelchair
OLB ❑ Automatic Internal Cardiac Defibrillator	OKB ❑ Colostomy	❑ Crutches
OLC ❑ Pacemaker	OKD ❑ Tracheostomy	❑ Other – List:
OLD ❑ Gastrostomy tube	OKE ❑ Urostomy	
OLE ❑ Jejunostomy tube	OK ❑ Other	
❑ Brace		
❑ Prosthesis – List:		
❑ Other medical devices:		

Parent/Guardian Signature _____ **Date** _____

Edmonds School District

HS-518
Immunization Packet

To: Parents of Edmonds School District Students
From: Student Health Services Department

Requirements for school enrollment per Washington State Law (RCW 28A.210.080)

- A Completed Certificate of Immunization Status. This can be one of the following:
  - A CIS printed from the Washington Department of Health MyIR system or a CIS from another state
  - A physical copy of the CIS form with a healthcare provider signature
  - A physical copy of the CIS with accompanying medical immunization records from a healthcare provider verified and signed by school staff

  OR
- Notification to the school that an immunization series has been started
  This will be completed in accord with your health care provider's recommended schedule. Immunizations are available from your private health care provider or you may obtain vaccines from Community Health Center of Snohomish County. WWW.chcsno.org Conditional status will only be granted to students if they have started the series of a required immunization that they are due to receive. As a requirement to attend school all immunization series need to be complete or started. A medically verified record of this status must be presented to the school on or before the first day of attendance.
  OR
- Complete a Certificate of Exemption (C.O.E.) in addition to the Certification of Immunization
  A licensed health care provider needs to sign the Certificate of Exemption for a parent or guardian to exempt their child from school immunization requirements. The signature verifies that the provider has spoken to the parent or guardian about the benefits and risks of immunization. A parent or guardian can also turn in a signed letter from a healthcare provider stating the same information. If there is an outbreak at school of any vaccine-preventable disease for which your student is exempted, your student will be excluded from school for the duration of the outbreak.

  All students enrolled at a public school must follow the immunization rules, even if participating in an alternative school or district program. These include home-school programming, vocational or technical programming, Running Start, and any virtual school program. All students will need to have a completed Certificate of Immunization Status (CIS) and/or Certificate of Exemption (COE) on file at the school to participate in school instruction and activities.

Printing a Certificate of Immunization from MyIR is the best option for obtaining student immunization records.

Create a MyIR account (Washington State Dept. of Health).

Access your Family's Immunization Information

- Option 1: Sign up for MyIR Mobile at MyIRmobile.com to view and print your family's immunization information, including COVID vaccination.
- Option 2: Visit your local pharmacy, clinic, or school
- Option 3: Request a complete immunization record from your healthcare provider
- Option 4: Request a complete immunization record from the Department of Health

Download and print the Certificate of Immunization

Parents– Are Your Kids Ready for School?

Required Immunizations for School Year 2024 2025

Instructions: To see which vaccines are required for school, find your child's grade in the first column. Look at the matching row across the page to find the amount of vaccines required for your child to enter school.

	DTaP/Tdap (Diphtheria, Tetanus, Pertussis)	**Hepatitis B**	**Hib** (*Haemophilus influenzae* type B)	**MMR** (Measles, mumps, rubella)	**PCV** (Pneumococcal Conjugate)	**Polio**	**Varicella** (Chickenpox)
Preschool Age 19 months to <4 years on September 1st	4 doses DTaP	3 doses	3 or 4 doses* (depending on vaccine)	1 dose	4 doses*	3 doses	1 dose**
Preschool/Transitional Kindergarten 4 years of age or older on September 1st	5 doses DTaP*	3 doses	3 or 4 doses* (depending on vaccine) (Not required at 5 years of age or older)	2 doses	4 doses* (Not required at 5 years of age or older)	4 doses*	2 doses**
Kindergarten through 6th	5 doses DTaP*	3 doses	Not Required	2 doses	Not Required	4 doses*	2 doses**
7th through 11th	5 doses DTaP* *Plus* Tdap at age ≥10 years	3 doses	Not Required	2 doses	Not Required	4 doses*	2 doses**
12th	5 doses DTaP* *Plus* Tdap at age ≥7 years	3 doses	Not Required	2 doses	Not Required	4 doses*	2 doses**

*Vaccine doses may be acceptable with fewer than listed depending on when they were given. **Health care provider verification of history of chickenpox disease is also acceptable.
Students must get vaccine doses at the correct timeframes to be in compliance with school requirements. Talk to your health care provider or school staff if you have questions.
Find information on other important vaccines not required for school at: www.immunize.org/cdc/schedules.

To request this document in another format, call 1-800-525-0127.
Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov

DOH 348-295 Dec. 2023

Washington State Department of HEALTH

Certificate of Immunization Status (CIS)

Reviewed by: Date:
Signed COE on File? □ Yes □ No

Please print. See back for instructions on how to fill out this form or get it printed from the Washington State Immunization Information System.

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):

I give permission to my child's school/child care to add immunization information into the Immunization Information System to help the school maintain my child's record.	Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status.
X _____ **Parent/Guardian Signature** **Date**	X _____ **Parent/Guardian Signature Required if Starting in Conditional Status** **Date**

▲Required for School ● Required Child Care/Preschool	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
Required Vaccines for School or Child Care Entry						
●▲ DTaP (Diphtheria, Tetanus, Pertussis)						
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)						
●▲ DT or Td (Tetanus, Diphtheria)						
●▲ Hepatitis B						
● Hib (*Haemophilus influenzae type b*)						
●▲ IPV (Polio) (any combination of IPV/OPV)						
●▲ OPV (Polio)						
●▲ MMR (Measles, Mumps, Rubella)						
● PCV/PPSV (Pneumococcal)						
●▲ Varicella (Chickenpox) ☐ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
COVID-19						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV/MPSV (Meningococcal Disease types A, C, W, Y)						
MenB (Meningococcal Disease type B)						
Rotavirus						

Manually completed form must have doctor signature or medically verified immunization documentation attached.

Documentation of Disease Immunity (Health care provider use only)

If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.

I certify that the child named on this CIS has:
□ A verified history of varicella (chickenpox) disease.
□ Laboratory evidence of immunity (titer) to disease(s) marked below.

□ Diphtheria	□ Hepatitis A	□ Hepatitis B
□ Hib	□ Measles	□ Mumps
□ Rubella	□ Tetanus	□ Varicella

□Polio (all 3 serotypes must show immunity)

►

Licensed Health Care Provider Signature Date

►

Printed Name

I certify that the information provided on this form is correct and verifiable.

Health Care Provider or School Official Name: _____ Signature: _____ Date:_____
If verified by school or child care staff the medical immunization records must be attached to this document.

Instructions for completing the Certificate of Immunization Status (CIS): Print the from the Immunization Information System (IIS) or fill it in by hand.

To print with the immunization information filled in:
Ask if your health care provider's office enters immunizations into the WA Immunization Information System (Washington's statewide registry). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.

To fill out the form by hand:
1. Print your child's name and birthdate, and sign your name where indicated on page one.
2. Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as DTaP, Hepatitis B as Hep B, and Polio as IPV.
3. If your child had chickenpox (varicella) disease and not the vaccine, a health care provider must verify chickenpox disease to meet school requirements.
   - □ If your health care provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
   - □ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.
4. If your child can show positive immunity by blood test (titer), have your health care provider check the boxes for the appropriate disease in the Documentation of Disease Immunity section, and sign and date the form. You must provide lab reports with this CIS.
5. Provide proof of medically verified records, following the guidelines below.

Acceptable Medical Records
All vaccination records must be medically verified. Examples include:

- A Certificate of Immunization Status (CIS) form printed with the vaccination dates from the Washington State Immunization Information System (IIS), MyIR, or another state's IIS.
- A completed hardcopy CIS with a health care provider validation signature.
- A completed hardcopy CIS with attached vaccination records printed from a health care provider's electronic health record with a health care provider signature or stamp. The school administrator, nurse, or designee must verify the dates on the CIS have been accurately transcribed and provide a signature on the form.

Conditional Status
Children can enter and stay in school or child care in conditional status if they are catching up on required vaccines for school or child care entry. (Vaccine series doses are spread out among minimum intervals, so some children may have to wait a period of time before finishing their vaccinations. This means they may enter school while waiting for their next required vaccine dose). To enter school or child care in conditional status, a child must have all the vaccine doses they are eligible to receive before starting school or child care.

Students in conditional status may remain in school while waiting for the minimum valid date of the next vaccine dose plus another 30 days time to turn in documentation of vaccination. If a student is catching up on multiple vaccines, conditional status continues in a similar manner until all of the required vaccines are complete.

If the 30-day conditional period expires and documentation has not been given to the school or child care, then the student must be excluded from further attendance, per RCW 28A.210.120. Valid documentation includes evidence of immunity to the disease in question, medical records showing vaccination, or a completed certificate of exemption (COE) form.

Reference guide for vaccine trade names in alphabetical order For updated list, visit https://www.cdc.gov/vaccines/terms/usvaccines.html

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Fluarix	Flu	Havrix	Hep A	Menveo	Meningococcal	Rotarix	Rotavirus (RV1)
Adacel	Tdap	Flucelvax	Flu	Hiberix	Hib	Pediarix	DTaP + Hep B + IPV	RotaTeq	Rotavirus (PV5)
Afluria	Flu	FluLaval	Flu	HibTITER	Hib	PedvaxHIB	Hib	Tenivac	Td
Bexsero	MenB	FluMist	Flu	Ipol	IPV	Pentacel	DTaP + Hib +IPV	Trumenba	MenB
Boostrix	Tdap	Fluvirin	Flu	Infanrix	DTaP	Pneumovax	PPSV	Twinrix	Hep A + Hep B
Cervarix	2vHPV	Fluzone	Flu	Kinrix	DTaP + IPV	Prevnar	PCV	Vaqta	Hep A
Daptacel	DTaP	Gardasil	4vHPV	Menactra	MCV or MCV4	ProQuad	MMR + Varicella	Varivax	Varicella
Engerix-B	Hep B	Gardasil 9	9vHPV	Menomune	MPSV4	Recombivax HB	Hep B		

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).