Welcome to NWR7! Please let us know how we can assist you in meeting your child's health needs while in school. Our office operates within the requirements of the State Department of Education regulations and Board of Education policies.

HEALTH OFFICE HOURS: 7:10 AM – 2:40 PM.

Dorothy Mitchell, RN
860-379-8525 Ext 2618
FAX: 860-379-8940
dmitchell@NWR7.org

Amanda D'Urso, RN
860-379-8525 Ext 2619
FAX: 860-379-8940
adurso@NWR7.org

Immunizations

All students must present proof of immunizations from a physician or local health agency upon enrollment in Region 7. Students not immunized due to religious reasons, must have on file a CT DPH Religious Exemption statement signed by the physician, parent and notarized prior to 4/28/202.

Students not immunized due to medical reasons, must have a CT DPH Medical Exemption Certificate signed by the parent or guardian and have attached a letter from the physician. Indicating that such immunization is medically contraindicated.

Students entering Grade 7:

The State of CT mandates that ALL 7th graders present proof of immunizations ***before the* START** of the 7th grade year. The 6th grade physical exam submitted to the elementary school will be accepted for documentation of mandatory 7th grade immunizations. If you did not submit a 6th grade physical, you will need to present proof of up-to-date immunizations before the end of July. In accordance with CT State law, your child ***will be excluded*** from 7th grade until this requirement is met.

Physical Examinations

NWR 7 Board policy examination (C.G.S. 10-2045a) mandates that all students must present evidence of a physical:

1. Upon enrollment to the district
2. 6th grade (submitted to the elementary school)
3. 10th grade

CT Health Assessment Record (Blue) Form must be completed in its entirety to include vision, auditory & scoliosis screenings. Telemedicine and camp physicals will not be accepted.

All 10th grade students must submit the physical ***before the end*** of the 10th grade academic year. In accordance with CT State law, your child ***will be excluded*** from 11th grade until this requirement is met.

Screenings

It is preferred that the private physician perform scoliosis screening during the physical exam. Those 7th grade girls and 9th grade boys who were not screened by their physician will be screened in school with parent permission. Any student whose screening indicates a possible problem will have a report of the finding mailed to the parent/guardian for a follow up with the physician.

Physician Notes

In keeping with FERPA guidelines for confidentiality & privacy, all medical notes must be brought/faxed directly to the Health Office. The nurses will communicate any restrictions to the appropriate staff. Telemedicine documentation of evaluation by a healthcare provider is accepted with the exception of physical examinations.

Student Health Emergency Information Forms

This confidential medical information, held on file in the health office, helps us provide for the health and safety of your child**.** These new "pink" forms must be completed upon entry to NWR7 and updated by the parent/guardian at the beginning of each new school year.

If you indicate that your child has asthma that requires a rescue inhaler or that they have a life-threatening allergy that requires an Epi-Pen, you MUST provide both the medication and a Medication Administration form signed by the physician and parent.

Students with Asthma should have an Asthma Action Plan filled out by doctor.
Students with life threatening allergies should have Allergy Action Plan filled out by doctor.

Without these medications and forms, your child will be excluded from all field trips.

Field Trips

Student must have an updated Health Emergency Form on file in health office. Those who self-carry inhalers, Epi pens, or diabetes supplies are expected to bring their medications from home for field trips. If this form is not on file, or medications are not available, your child will be excluded from field trips for their own safety

Administration of Medication in School

Nurses must follow CT State law and Board of Education policy re: the administration of medicine to your child. Only FDA medications will be administered during school hours if the desired effect cannot be achieved outside school hours.

1. All medications, including emergency self -carry medications, will be administered only with the following:
   a. Completion of a NWR Medication Administration Form (available on district site), signed by an authorized prescriber and written authorization of the parent.
2. Medication orders are valid for one academic year.
3. Verbal authorization/request by parents is **not** permitted by law
4. All medications must be brought to the health office by an adult with the exception of emergency medications which may be transported by the student:
   a. Epi pens, Inhaler & Insulin supplies
5. Students who self -carry these emergency medications must have them on their person at all times in case of an emergency (i.e.: a lock down, fire drill etc.)
6. Parents are encouraged to provide a backup medication available in the health office.
7. Standing order for Tylenol, Ibuprofen or Tums is available through the district physician. Parents must complete the (purple) permission form in order for their child to receive medication.
8. All medication will be dispensed in the Health Office only.
9. Parents must pick up all unused medication within one week of the end of the school year.
10. By law, parents MUST pick up all controlled substances at the end of the academic year.

Formulary of First Aid Preparations

Alcohol- Isopropyl	For skin prep
Aspirin- low dose	For use by staff for discomfort
Bacitracin, Triple Antibiotic Ointment	For use for minor abrasions
Caladryl, Calamine, Hydrocortisone Cream ½%	For use topically for insect bites or skin irritations
Chloraseptic spray or warm water saline (1:18)	For use for minor throat irritations
Contact Solution	For use for self-cleaning of contacts
Diphenhydramine (Benadryl) 12.5mg/5ml or 25mg tablets	For emergency treatment of allergic reaction
Epinephrine 0.15mg or 0.3mg auto-injector	For emergency treatment of allergic reaction
Eye Irrigating Saline Solution	For use to flush eyes
First Aid Cream, Burn Gel/ Spray, or Aloe	Topical use for minor burns and skin irritations
Glucose gel or tablets	For the treatment of low blood sugar
Hydrogen Peroxide, BZK Wipes	For use topically to clean wounds
Ibuprofen 200 mg tablets	For headaches, menstrual or muscle cramps, pain due to orthodontic adjustments or toothaches
Naloxone (Narcan)	For emergency treatment of opioid overdose
Orajel	Topical use for minor toothache, canker sore, cold sore or orthodontic discomfort
Oxygen	May be used for insufficient oxygen intake
Petroleum Jelly, Vaseline or Lotion	Topical use for chapped lips or dry skin
Sucrets or throat discs	For use for minor throat irritations
Sting Relief swabs or wipes	Topical use for insect bites or stings
Tylenol /Acetaminophen 325 mg tablets	For headaches, menstrual or muscle cramps, pain due to orthodontic adjustments or toothaches
Tums tablets	For upset stomach or indigestion

Sports Participation

Sports registration is electronically through Family ID. To facilitate the eligibility validation process parents should complete the registration form a minimum of **two weeks prior to the tryout dates**.

Please be advised registration does not confirm eligibility. The following items are required:

1. Physical examination completed less than 13 months (per current CIAC guideline) prior must be on file in the Health Office

   Upload physicals forms to Family ID, mailed to school or delivered directly to the Health Office.

2. There are no current physician-imposed restrictions from previous injuries or conditions A note for the primary care provider is required to provide clearance from a current injury of condition to resulted in exclusion from sports

3. Those with history of concussion must have on file in the Nurses Office a physician note clearing the concussion, and have completed the return to play protocol with the Athletic Trainer.

You may use Family ID at any time to check for when your physical expires. You will also get an email from Family ID 60 days in advance of the expiration date of your physical.

Illness or Injury

If a student becomes injured or ill in school, he/she should report to the Health Office. The nurse will evaluate the child and contact the parent as indicated. Students must not leave the building because of illness/injury without authorization from the school nurse, as this may result in an unexcused absence.

Communicable/Infectious Diseases

Students with any medical condition that may expose others within the school setting to disease or contagious and infectious conditions will be excluded from school and referred for medical diagnosis and treatment.

The following guidelines should be helpful to you in determining if your child should be in school:

1. Fever free (less than 100.0) for 24 hours before returning to school without the use of fever reducing medicine.
2. No episodes of vomiting for 24 hours.
3. No active communicable and/ or contagious infections
4. On antibiotics for 24 hours before returning from a communicable infection

Requirements for Return to School after COVID Illness / Exposure

Students regardless of vaccination status who develop COVID-19 symptoms are required to remain home from school and notify the nurse's office. Testing is recommended at that time.

COVID-19 symptoms:

Fever/chills	Shortness of breath	Sore throat
Cough	Headache	Loss of taste/smell
Fatigue	Muscle/body aches	Congestion/runny nose
Nausea	Vomiting	Diarrhea

Test Options: PCR, Rapid & Rapid home tests. Report results to the nurse's office.

If the student has **tested positive**: isolate for 5 days from symptom onset or test date.
Return to school:

- Return on day 6 after completion of 5 full days of isolation
- Fever free without the use of fever-reducing medications for 24 hours
- Significant improvement or resolution of symptoms
- Continue to wear well-fitted mask around others for 5 additional days

If the student has tested negative repeat testing recommended in 48 hours. Students must meet the above noted guidance for return to school after illness.

Students who had a known exposure:
Fully vaccinated: Continue in-person learning, wear mask for 10 days around others, test on day 5 or sooner if symptomatic.

Unvaccinated or partially vaccinated: quarantine at home for 5 days. Test on day 5 or sooner if symptomatic. If no symptoms or test is negative may return to school on day 6. Continue to wear a well-fitted mask around others for 5 additional days

Please check the district website for updated COVID information as guidance changes frequently

Requirements for Return to School after Surgery or Serious Illness/Injury

Students returning to school after surgery or a serious illness, concussion, or hospitalization must provide a note from a physician indicating clearance to return to school.

The note should include any restrictions (i.e.: no physical education) or required accommodations (i.e.: elevator use). The physician following reevaluation must update continued restrictions.

Documentation from the physician is required for the discontinuation of any restrictions.

NORTHWESTERN REGIONAL SCHOOL DISTRICT 7

BARKHAMSTED, COLEBROOK, NEW HARTFORD and NORFOLK

January 2024

Dear Parent / Guardian:

Our medical advisor Dr. Ann Milanese has provided a standing order for the administration of Regular Strength **Tylenol/Acetaminophen** (325 mg) tablets or **Ibuprofen**(200mg) tablets, to be used in the case of a minor headache, fever, orthodontic discomfort, menstrual discomfort and/or muscle cramps. A standing order for the administration of regular strength **Tums** antacid tablets as directed for the relief of stomach upset or indigestion is also provided.

This order in no way changes the general medication administration policy of the school district.
NO MEDICATION, PRESCRIPTION OR OVER-THE-COUNTER MAY BE ADMINISTERED WITHOUT A SIGNED DOCTORS ORDER AND PARENT CONSENT.

Please complete the form below and have your child return the entire form to the Health Office**.** Any questions, please call the Health Office.

Dorothy Mitchell, RN
860-379-8525 Ext. 2618

Amanda D'Urso, RN
860-379-8525 Ext. 2619

2024 – 2025 School Year

The School Nurse has permission to administer to my child (please check all that apply) in keeping with the school's standing order as given by Dr. Ann Milanese, medical advisor.

Tylenol / Acetaminophen (325 mg) - 1 tablet _____ Ibuprofen (200 mg) - 1 tablet _____

Tylenol /Acetaminophen (325 mg) - 2 tablets_____ Ibuprofen (200 mg) - 2 tablets _____

Tums/Antacid – 1 tablet _____

Tums/Antacid – 2 tablets _____

No Medication Required _____

_____ _____
Student Name (Please Print) Parent/Guardian Signature

_____ _____
Grade Date

NORTHWESTERN REGIONAL SCHOOL DISTRICT 7

2024 - 2025

Student Health Emergency Information to be Completed/Updated Each School Year

Name_____ Birth Date_____ Grade_____
(Last) (First) (Middle)

Address_____ Home Phone_____

	Mother	Father	Step-Parent	Guardian
Name				
Business Phone				
Cell Phone				

(Please circle with whom student lives)

Emergency Contact: Please call the following person (s) if parent or guardian cannot be reached

1._____ _____ _____
Name Phone Town

2. _____ _____ _____
Name Phone Town

Student's Physician _____ Phone_____

Student's Dentist _____ Phone_____

Health Insurance Yes No Would you like information about CT HUSKY Plan? Yes No

I, the undersigned parent/guardian, give permission to the school nurse to exchange pertinent health information as related to health & safety about my child with his/her teacher

In the event of an emergency, I understand that every effort will be made to reach the parents. In the event I cannot be reached, I give permission for my child to be transported to the appropriate medical facility

_____
(Parent/Guardian Signature)

PLEASE TURN OVER & COMPLETE THE SECOND SIDE OF THIS FORM

Student Health History- Annual Update
This is NOT a substitute for the state mandated Physical Exam in grade 7 & 10

ALLERGIES

To What? _____ Y N

Life Threatening? Y N

Does Student Need Epi Pen? Y N
*Physician Medication Authorization Form required if you circle YES.

Medication Authorization provided Y N

CARDIAC PROBLEMS Y N

Cardiac condition_____

Restrictions for Physical Activity Y N

Does student have pacemaker? Y N

Does student have a defibrillator? Y N

ASTHMA Y N

Does student need rescue inhaler. Y N
*Physician Medication Authorization Form required if you circle YES.

Medication Authorization provided Y N

Student will self-carry inhaler Y N

SEIZURES Y N

Type of seizures _____

Does student need Diastat? Y N
*Physician Medication Authorization Form required if you circle YES.

Does student need nasal Midazolam ? Y N

Medication Authorization provided Y N

DIABETES Y N

Does student use CGM ? Y N

Does student use an insulin pump? Y N

Type of pump_____

Diabetes Management Plan provided Y N

*** Parents must maintain supplies in Health Office**

*** Please contact Health Office regarding nursing access to CGM monitoring**

Other Health Conditions: _____

Does student take any medicine at home on a regular basis? N Y

Medication: _____ Reason Taking: _____

Does the student need to take any medication at school? N Y *Additional form REQUIRED

Medication: _____ Reason Taking: _____

Physician Medication Authorization Form required for each medication to be administered in school with the exception of standing order for Tylenol or Ibuprofen. Medication must be delivered by parent or guardian.

I understand that no student may carry any prescription or over-the-counter drug in school or on school property with the exception of emergency medications: rescue inhalers, Epi pens or insulin.

_____ _____

Parent Signature **Student Signature**

NORTHWESTERN REGIONAL SCHOOL DISTRICT 7

SCHOOL MEDICATION AUTHORIZATION

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician's assistant, and for interscholastic and intramural sports only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, qualified school personnel to administer medication. Medications must be in the original properly labeled container. Prescription medication should be in the labeled container dispensed by a pharmacist.

This authorization is in effect for the school year: 2024 – 2025 To include extended year program.

Self-administration of asthma inhalers and cartridge injectors (for medically diagnosed allergies) may be authorized by the prescriber and parent/guardian. All other medications considered for self-administration must be approved by the school nurse in accordance with Board policy to confirm student safety and competency with medication procedure.

Prescriber's Authorization

Name of Student _____ **Date of Birth** _____

Condition for which medication is indicated: _____

Medication Allergies ☐ NKDA ☐ Yes: _____

Medication: & generic name _____ **Dose:** _____ ☐mg ☐puffs ☐amp ☐other **Route:** ☐PO ☐GT / NGT ☐Inhaled ☐ Injected

Side Effects: ☐Not relevant _____

Time of Administration _____ ☐AM ☐PM

If PRN, frequency, Q_____ Hours

Provider Name & Phone/Fax Numbers (printed or stamped)

Prescriber's Authorization for Self-Administration ☐Yes ☐No

Confirms that the student has been instructed to safely and properly administer this medication

Prescriber's Signature _____ **Date:** _____

Parent/Guardian Authorization

I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a **3-month supply of medication**. I understand that this medication will be destroyed if not picked up within one week following discontinuation of the medication or the last day of school, whichever comes **first.**

I also give my consent for the exchange of information between the prescribing health care provider and school nurse, as needed for the safe administration of this medication and the safe management of the condition for which it is prescribed.

Parent/Guardian Authorization for Self-Administration ☐ Yes ☐ No

Parent/Guardian Signature: _____ **Date:** _____

Parent's Home Phone# **Work/ Cell #**

School nurse approval for Self-Administration ☐NR* ☐Yes ☐No _____

**NR mean Not required for inhalers or cartridge injectors* Signature Date

State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part 1 of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height**_____in. /_____% ***Weight**_____lbs. /_____% **BMI**_____/_____% **Pulse** _____ ***Blood Pressure**_____/ _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***Speech** (school entry only)	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
*Explain:*_____
Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____
Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ Yes ❑ No
Risk Assessment	**Describe Risk Factors**		
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____		❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other _____

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____

Signature of Parent/Guardian Date

_____

Signature of health care provider DMD / DDS / MD / DO / APRN / PA/ RDH Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 1/2022

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Religious Exemption: _____

Religious exemptions must meet the criteria established in Public Act 21-6: https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf.

Medical Exemption: _____

Must have signed and completed medical exemption form attached.
https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number