Lorain City Schools

HEALTH SERVICES / *SERVICIOS DE SALUD*
IMMUNIZATION FORM / *FORMULARIO DE INMUNIZACIÓN*

Name of Child ____ Date of Birth___________
Nombre del Niño **First/***Primer Nombre* **Last/***Apellido* *Fecha de Nacimiento*

Immunizations are required by sections 3701.13, 3313.671, and 5104(E) of the Ohio Revised Code. Those students not immunized as stated by Ohio Law are to be excluded from school attendance. Therefore, it is important that your child's records be completed. *Las vacunas son requeridas por las secciones 3701.13, 3313.671 y 5104 (E) del Código Revisado de Ohio. Aquellos estudiantes no inmunizados como lo establece la Ley de Ohio deben ser excluidos de la asistencia escolar. Por lo tanto, es importante que se completen los registros de su hijo(a).*

The following immunization are required for students**:** *se requiere las siguiente inmunizaciones por estudiante:*

5th DTaP needed if 4th given before 4th birthday
4th Polio needed if 3rd given before 4th birthday
2-MMR – 1st after 1st birthday, 2nd before kindergarten
3- Hep B required for kindergarten
2- Varicella
Hib needed for **pre school**
1 Tdap (prior to entering **7th grade**)
2- MCV4 (1) dose meningococcal vaccine must be administered prior to entry*** **7th grade**
(2) doses meningococcal vaccine must be administered prior to entry*** **12th grade**

COMPLETE THESE IMMUNIZATIONS
LLENE LAS INMUNIZACIONES COMPLETADAS

IMMUNIZATION RECORD	DATES			
DTaP	**#1**__________	**#2**__________	**#3**__________	**#4**__________
	#5__________			
Polio	**#1**__________	**#2**__________	**#3**__________	**#4**__________
	#5__________			
MMR	**#1**__________	**#2**__________	**#3**__________	**#4**__________
	#5__________			
Hib	**#1**__________	**#2**__________	**#3**__________	**#4**__________
	#5__________			
Hep B	**#1**__________	**#2**__________	**#3**__________	**#4**__________
	#5__________			
VAR	**#1**__________	**#2**__________	**#3**__________	
MEN	**#1**__________	**#2**__________	**#3**__________	
Tdap	**#1**__________			

If the above immunizations have been administered already, please send a copy of your child's completed immunization record to the school. Please mark it "attention Health Professional*". Si las vacunas anteriores ya se han administrados envíe una copia del registro de vacunación completo de su hijo(a) a la escuela. Por favor, márquelo como "atención Profesional de la Salud".*

HISTORY OF DISEASES DATES *(Antecedentes de enfermedades y fechas)*

(9 day measles/*Sarampión paperas*) ____________________
(3 day measles/*Sarampión paperas*) ____________________
Chicken Pox/*Varicela* ______________________________

Signature of Physician ____________________________Date________________

Signature of Parent/Guardian________________________Date________________
Firma de padre/tutor

M-07 07/23