

INDEPENDENT SCHOOL DISTRICT 196
Rosemount-Apple Valley-Eagan Public Schools
Educating our students to reach their full potential

Series Number 501.5.5.1.1P Adopted June 2014 Revised _____

Title **Follow-up Notification of Immunization Law Requirements for Early Childhood Students**

Date _____

Dear parent/guardian of _____,
print student name

A. Your child must be current on all required immunizations or provide documentation of exemption **in order to remain in school.** We do not have a record of the following immunizations:

<input type="checkbox"/> DTaP	<input type="checkbox"/> Varicella
<input type="checkbox"/> Polio	<input type="checkbox"/> Pneumococcal (2-24 months)
<input type="checkbox"/> MMR	<input type="checkbox"/> Hepatitis A
<input type="checkbox"/> Hib	<input type="checkbox"/> Hepatitis B

B. Please complete one of the four options below and provide the appropriate documentation to the school nurse:

1. Once the immunization indicated above has been given, write the date (month, day, year) of the immunization on the Early Childhood Immunization Form located on the reverse of this document, sign where indicated, and return this document to your school nurse; **or**
2. If your child has received at least one of a series of immunizations and will complete the series within the next eight months, the physician must indicate such and sign the Early Childhood Immunization Form located on the reverse of this document, then return the document to your school nurse; **or**
3. If your child will not receive the immunization due to a medical contraindication or laboratory evidence of immunity, you must give the school nurse a statement signed by a physician (you may use the statement on the reverse of this document), **or**
4. If your child will not receive the immunization due to conscientiously held beliefs, you must give the school nurse a notarized statement signed by the parent or guardian (you may use the statement on the reverse of this document).

C. If you meet any one of the following Minnesota Vaccines for Children (MnVFC) eligibility criteria, you may call Dakota County Public Health (952-891-7999) to receive low-cost vaccinations (There may be no charge for the vaccine for children meeting the criteria listed below):

- You are uninsured;
- You are enrolled in Minnesota Medical Assistance (MA), Minnesota Care (MnCare) or Prepaid Medical Assistance Program (PMAP);
- You are an American Indian or Alaskan Native, or
- You have health insurance that does not cover the cost of the vaccine.

D. Submit proof of compliance with the state immunization law to the school nurse. Call the school nurse if you have any questions regarding immunizations for your child. We appreciate your timely attention to this matter.

School District Official _____ School Nurse _____

Early Childhood Immunization Form

Must be on file **before** a child attends any early childhood programs*

Name _____

Birthdate _____

Date of Enrollment _____

Minnesota law requires children enrolled in early education programs to be immunized against certain diseases or file a legal medical or conscientious exemption.

Parent/Guardian:

You may attach a copy of the child's immunization history to this form OR enter the MONTH, DAY, and YEAR for all vaccines your child received. Enter MED to indicate vaccines that are medically contraindicated including a history of disease, or laboratory evidence of immunity and CO for vaccines that are contrary to parent or guardian's conscientiously held beliefs.

Sign or obtain appropriate signatures on reverse. Complete section 1A or 1B to certify immunization status and section 2A to document medical exemptions (including a history of varicella disease) and 2B to document a conscientious exemption.

Additionally, if a parent or guardian would like to give permission to the early education program to share their child's immunization record with Minnesota's immunization information system, they may sign section 3 (optional).

For updated copies of your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

*Early childhood programs are defined as programs that provide instructional or other services to support children's learning and development and:
 • Serve children from birth to kindergarten.
 • Meet at least once a week for at least six weeks or more during the year.

This includes but not limited to early childhood family education (ECFE), early childhood special education (ECSE), school readiness programs, and other school district preschool and pre-kindergarten programs.

Type of Vaccine	DO NOT USE (✓) or (✕)	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
Required (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.)						
Diphtheria, Tetanus, and Pertussis (DTaP, DTP) • 3 doses during 1st year (at 2-month intervals) • 4 th dose at 12-18 months • 5 th dose at 4-6 years <i>Indicate vaccine type: DTaP or DTP</i>						
Polio (IPV, OPV) • 2 doses in the first year • 3 rd dose by 18 months • 4 th dose at 4-6 years						
Measles, Mumps, and Rubella (MMR) • Required for children 15 months and older • 1 st dose on or after 1 st birthday • 2 nd dose at 4-6 years						
Haemophilus influenzae type b (Hib) • 2-3 doses in the first year • 1 dose required after 12 months or older • For unvaccinated children 15-59 months, 1 dose is required • Not required for children 5 years or older						
Varicella (chickenpox) • Required for children 15 months and older • 1 st dose on or after 1 st birthday • 2 nd dose at 4-6 years						
Pneumococcal Conjugate Vaccine (PCV) • 3 doses in the first year • 4 th dose after 12 months • At least 1 dose is recommended for children 24-59 months in child care						
Hepatitis B (hep B) • 2-3 doses in the first year • 3 rd dose (final dose) as late as 18 months						
Hepatitis A (hep A) • 2 doses separated by 6 months for children 12 months and older						
Recommended						
Rotavirus (2-3 doses between 2 and 6 months)						
Influenza (annually for children 6 months or older)						

Name _____

Instructions, please complete:

Box 1 to certify the child's immunization status

Box 2 to file an exemption (medical or conscientious)

Box 3 to provide consent to share immunization information (optional)

1. Certify Immunization Status. Complete A or B to indicate child's immunization status.

A. Children who are 15 months or older:
 For children who are 15 months or older and who have received all the immunizations required by law for early childhood programs:
 I certify that the above-named child is at least 15 months of age and has completed the immunizations which are required by law for child care.

 Signature of Parent / Guardian OR Physician / Nurse Practitioner / Physician Assistant / Public Clinic
 _____ Date

B. Children who are 15 months or younger:
 For children who are younger than 15 months OR have not received all required immunizations:
 I certify that the above-named child has received the immunizations indicated. In order to remain enrolled this child must receive all required vaccines within 18 months from initial enrollment date. The dates on which the remaining doses are to be given are:

 Signature of Physician / Nurse Practitioner / Physician Assistant / Public Clinic
 _____ Date

2. Exemptions to Immunization Law. Complete A and/or B to indicate type of exemption.

A. Medical exemption:
 No child is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a child to receive a medical exemption, a physician, nurse practitioner, or physician assistant must sign this statement:
 I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was laboratory confirmed (for varicella disease see * below). List exempted immunization(s):

 Signature of physician/nurse practitioner/physician assistant
 _____ Date

*History of varicella disease only. In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in _____ (year)

 Signature of physician/nurse practitioner/physician assistant (If disease occurred before September 2010, a parent can sign.)

B. Conscientious exemption:
 No child is required to have an immunization that is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations may endanger the health or life of the child or others they come in contact with. In a disease outbreak, children who are not vaccinated may be excluded in order to protect them and others. To receive an exemption to vaccination, a parent or legal guardian must complete and sign the following statement and have it notarized:
 I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s):

 Signature of parent or legal guardian
 _____ Date

Subscribed and sworn to before me this: _____ day of _____ 20____

 Signature of notary

3. Parental/Guardian Consent to Share Immunization Information (optional):
 Your child's early childhood program is asking your permission to share your child's immunization documentation with MIIC, Minnesota's immunization information system, to help better protect children from disease and allow easier access for you to retrieve your child's immunization record. You are not required to sign this consent; it is voluntary. In addition, all the information you provide is legally classified as private data and can only be released to those legally authorized to receive it under Minnesota law.
 I agree to allow early childhood program personnel to share my child's immunization documentation with Minnesota's immunization information system:

 Signature of parent or legal guardian
 _____ Date