DISTRITO ESCOLAR INDEPENDIENTE 196
Escuelas Públicas de Rosemount-Apple Valley-Eagan
Educar a nuestros estudiantes para que alcancen todo su potencial

Números de serie **501.5.5.3P** Adoptado **Enero de 2004** Revisado **Junio de 2014**

Título **Notificación de los requisitos de la Ley de Inmunización para Estudiantes del Ciclo Primario (30 días o al completar las series)**

Estimado, padre, madre o tutor de _____, Fecha _____
Escribir en letra de imprenta el nombre del estudiante

Con el fin de estar en conformidad con la ley estatal, su hijo(a) necesita estar al día con todos los requisitos de inmunización o proveer documentación de exención **para permanecer en la escuela.** No tenemos registro de:

____ 2° Inmunización MMR (Sarampión, papera, rubéola)
____ 2° Inmunización contra la varicela
____ Serie de 3-dosis de vacuna contra la HepB (Hepatitis B)
____ Tdap, DTP (Tétano, difteria y convulsa)
____ 2° Inmunización contra HepB (Hepatitis B)
____ 3° Inmunización contra HepB (Hepatitis B)
____ Inmunización contra Poliomielitis (IPV,OPV)

tal como lo requiere la ley del estado para su hijo(a). Si no recibimos comprobante de esta/estas inmunización(es) o la documentación de exención en la oficina de la enfermera escolar, para las fechas registradas al final de esta carta de inscripción, **no se le permitirá** a **su hijo(a) asistir a la escuela hasta que se hayan cumplido los requisitos legales.**

Existen distintas formas de cumplir con esta ley:

1. Una vez que la inmunización indicada se realice, escriba la fecha (día; mes, año) en el Formulario de Inmunización del Estudiante en el reverso de este documento, firme donde se indica, y entregue a la enfermera escolar; ***o***
2. Si su hijo o hija recibió al menos una inmunización de la serie y completará el resto dentro de los ocho meses, el médico deberá indicar lo anterior y firmar el Formulario de Inmunización del Estudiante en el reverso de este documento; luego entréguelo a la enfermera escolar; ***o***
3. Si su hijo o hija no recibe la inmunización por contraindicación médica o por evidencia de laboratorio concerniente a la inmunidad, debe entregar a la enfermera escolar un comprobante firmado por un médico (puede utilizar la declaración en el reverso de este documento), ***o***
4. Si su hijo o hija no recibirá inmunización debido a convicciones profundas, debe entregar a la enfermera escolar una declaración certificada por notario público, firmada por el padre, madre o tutor (puede utilizar la declaración en el reverso de este documento).

Si cumple con alguno de los siguientes criterios de elegibilidad de Vacunas para niños de Minnesota (VPNMn) comuníquese con la Oficina de Servicios de Salud del Condado de Dakota (952-891-7999) para recibir vacunas de bajo costo. (Las vacunas para niños no tendrán costo si se cumple con los criterios descriptos abajo):

- No tiene seguro;
- Se encuentra inscripto en Minnesota Medical Assistance (MA), Minnesota Care (MnCare) o Programa de Asistencia Médica Prepaga (Prepaid Medical Assistance Program, PMAP);
- Usted es nativo Americano o nativo de Alaska, o
- Su seguro médico no cubre el costo de la vacuna.

De acuerdo con el estatuto 121A.15 del estado de Minnesota (Ley de Inmunización para Escolares), no se le permitirá a su hijo asistir a la escuela, si la enfermera escolar no ha recibido una de las pruebas de cumplimiento arriba mencionadas antes del _____ (30 días calendario a partir
fecha
de la fecha de la notificación) para_____ **y/o el** _____ **(fecha de**
inmunización fecha
finalización de la serie de 8 meses) para_____**.**
inmunización

Apreciamos su atención oportuna en este asunto. Si tiene alguna pregunta, por favor comuníquese con la enfermera escolar.

Atentamente,
Director _____ Enfermera escolar _____

Student Immunization Form

Student Name _____

Birthdate _____Student Number _____

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

FOR SCHOOL USE ONLY
( ) Complete; booster required in _____
( ) In process; 8 mos. expires _____
( ) Medical exemption for _____
( ) Conscientious objection for _____
( ) Parental/guardian consent _____

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 school 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 vaccination history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

School Personnel: Be sure to initial and date any new information that you add to this form after the parent/guardian submits it. Also, record combination vaccines (e.g., DTaP+HepB+IPV, Hib+HepB) in each applicable space.

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, DT) • for children age 6 years and younger • final dose on or after age 4 years					5th dose not required if 4rd dose was given on or after the 4th birthday
Tetanus and Diphtheria (Td) • for children age 7 years and older • 3 doses of Td required for children not up to date with DTaP, DTP, or DT series above					
Tetanus, Diphtheria and Pertussis (Tdap) • for children in 7th - 12th grade					
Polio (IPV, OPV) • final dose on or after age 4 years			4th dose not required if 3rd dose was given on or after the 4th birthday		
Measles, Mumps, and Rubella (MMR) • minimum age: on or after 1st birthday					
Hepatitis B (hep B)					
Varicella (chickenpox) • minimum age: on or after 1st birthday • vaccine or disease history required					
Meningococcal (MCV, MPSV) • for children in 7th - 12th grade • booster given at age 16 years					
Recommended					
Human Papillomavirus (HPV)					
Hepatitis A (hep A)					
Influenza (annually for children 6 months and older)					

Additional exemptions:

- **Children 7 years of age and older:** A history of 3 doses of DTaP/DTP/DT/Td/Tdap and 3 doses of polio vaccine meets the minimum requirements of the law.
- **Students in grades 7-12:** A Tdap at age 11 years or later is required for students in grades 7-12. If a child received Tdap at age 7-10 years another dose is not needed at age 11-12 years. However, if it was only a Td, a Tdap dose at age 11-12 years is required.
- **Students 11-15 years of age:** A 3rd dose of hepatitis B vaccine is not required for students who provide documentation of the alternative 2-dose schedule.
- **Students 18 years of age or older:** Do not need polio vaccine.

Student Name _____

Instructions, please complete:
Box 1 to certify the child's immunization status
Box 2 to file an exemption (medical or concientious)
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. Received all required immunizations:
I certify that this student has received all immunizations required by law.

_____
Signature of Parent / Guardian OR Physician / Public Clinic

_____ Date

B. Will complete required immunizations within the next 8 months:

I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B, varicella, measles, mumps, and rubella and will complete his/her diphtheria, tetanus, pertussis, hepatitis B, and/or polio vaccine series within the next 8 months.

The dates on which the remaining doses are to be given are:

_____
Signature of Physician / Public Clinic

_____ Date

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

A. Medical exemption:
No student is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a student 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 occured before September 2010, a parent can sign.)

B. Conscientious exemption:
No student 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 student or others they come in contact with. In a disease outbreak schools may exclude children who are not vaccinated 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 school is asking your permission to share your child's immunization documentation with MIIC, Minnesota's immunization information system, to help better protect students 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 school personnel to share my student's immunization documentation with Minnesota's immunization information system:

_____
Signature of parent or legal guardian Date

Developed by the Minnesota Department of Health - Immunization Program www.health.state.mn.us/immunize (12/13) #140-0155