South Windsor Public Schools
1737 Main Street • South Windsor, CT 06074
Phone: (860) 291-1200 • Fax: (860) 291-1291 • www.southwindsorschools.org

STUDENT PRE-REGISTRATION FORM

This form must be completed in order to begin the registration process for all students enrolling in South Windsor Public Schools. Please complete this form and bring to the school where you will receive the information needed to complete the online registration process. (See also "Registration and Residency Information Sheet" for required registration documentation.)

Today's Date: ______________________

Student Information

Please print legibly.

First Name: ______________________

Middle Name: ______________________

Last Name: ______________________ Suffix: ______________________

Gender: ☐ Female ☐ Male Date of Birth: ______________________

School Information

Grade Level: ☐ Pre-K ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Elementary Schools (K-5): ☐ Eli Terry Elementary School ☐ Orchard Hill Elementary School ☐ Philip R. Smith Elementary School ☐ Pleasant Valley Elementary School ☐ Wapping Elementary School

Middle School (6-8): ☐ Timothy Edwards Middle School

High School (9-12): ☐ South Windsor High School

Open Choice Student: ☐ No ☐ Yes

Parent Contact Information

Legal Guardian: ☐ Yes ☐ No

Primary Phone Number: ☐ H ☐ W ☐ C ______________________

Email Address: ______________________

Street Address: ______________________

City, State, Zip: ______________________

Print Name of Parent/Guardian Completing form: ______________________

Signature of Parent/Guardian: ______________________

(For Office Use Only)

☐ Verify student age/identity
☐ Verify parent/guardian identity documents
☐ Copy of Guardianship Documents (if applicable)
☐ Copy of student's birth certificate/passport/visa
☐ CREC Choice Registration and Release Forms (if applicable)
☐ Three (3) proofs of residency: ______________________

Powerschool Student Number: ______________

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RELEASE OF STUDENT RECORDS/INFORMATION

STUDENT INFORMATION

Student's Last Name, Student's First Name	Date of Birth

Grade Level: ☐ Pre-K ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8
☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ Other

SW School: ☐ ET ☐ OH ☐ PV ☐ PRS ☐ WES ☐ TEMS ☐ SWHS ☐ Other: ____________________

RELEASE INFORMATION

These records are for the purpose of educational planning and programming. This confidential information is being requested/released on the condition that no other party should have access to it without written consent of the parent/guardian, or the student, if s/he is 18 years of age or a graduate.

☐ **RECEIVE RECORDS**. I give permission for SWPS to receive the records indicated below **FROM** the following school:

☐ **RELEASE RECORDS**. I give permission for SWPS to release the records indicated below **TO** the following school:

Releasing/Receiving School	City, State

Phone Number (Releasing/Receiving School)	Fax Number (Releasing/Receiving School)

I, the undersigned parent/guardian of the above-referenced student, request that the following items be released as indicated above:

☐ Health Record
☐ Grades
☐ Achievement Scores
☐ Guidance Evaluation Check Lists
☐ Anecdotal Information
☐ Verbal Communication
☐ PPT Records (Notice of Meeting, Notice of Evaluation, Case Summaries, Referral, etc.)
☐ Psychological Record
☐ Social Work Record
☐ Speech Evaluation/Report
☐ I.Q. Scores
☐ Special Education Teacher Evaluation Report
☐ Other: ____________________

I understand that I may review the materials checked above before they are transmitted. I understand that one week from the date of this Release, the above materials will be forwarded as requested.

______________________________ Parent/Guardian Signature

______________________________ Date

FOR RECORDS BEING RECEIVED BY SOUTH WINDSOR PUBLIC SCHOOLS:
PLEASE DIRECT ALL RECORDS/CORRESPONDENCE TO:
Special Services Department, South Windsor Public Schools, 1737 Main Street, South Windsor, CT 06074

(For Office Use Only)

SASID:	Date Received:
Records Processed by:	Date Records Processed:

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www.southwindsorschools.org

PHYSICAL AND IMMUNIZATION ACKNOWLEDGMENT

State law requires that all students must be properly immunized. The most current requirements are listed on the enclosed form entitled, "Immunization Requirements for Newly Enrolled Students at Connecticut Schools."

State law also requires that each child have a health assessment prior to enrollment in Connecticut public schools. Since your child is new to our school system, a student may not begin his/her first day of school until a Health Assessment Record, including the details of full immunization and all other requirements, is verified by the school nurse prior to enrollment.

- Part I of the enclosed Health Assessment Record must be completed by the parent/guardian.
- Part II (Medical Evaluation) of the Health Assessment Record must be completed by the physician. All items asterisked (*) on the State of Connecticut Department of Education Health Assessment Record are required.

Incomplete forms will not be accepted.

For those students participating in school sports, an additional physician certification is required on an annual basis to confirm athletic eligibility.

- -

I understand that my child, ____, will be excluded from school if his/her Health Assessment and Immunization records are not available prior to enrollment.

______________________________ ______________________
Parent/Guardian Signature **Date**

______________________________ ______________________
PRINTED NAME **Daytime Phone Number**

☐ If you are applying for free/reduced status and believe your child may be eligible for a free physical by the school physician, please check here to request that it be provided. Your signature above constitutes permission for the school nurse to verify your child's eligibility with the Director of Food Services.

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AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL

Connecticut State Law requires a written order of an authorized prescriber and the written authorization of a parent or guardian of such child for a school nurse or, in the absence of such nurse, the principal or trained teacher to administer medicinal preparations to any student. Medications must be in pharmacy prepared containers and labeled with the name of child, name of drug, strength, dosage, frequency, authorized prescriber's name, and date of original prescription. Over the counter medications must be in the original sealed container. All medications must be brought in and picked up by a legally responsible adult.

Student's Last Name, First Name ______________________ **Student's Date of Birth** __________

**** ONE MEDICATION PER FORM. PHOTOCOPY AS NEEDED. PLEASE PRINT OR TYPE. ****

PHYSICIAN'S ORDER — DATE OF ORDER: ______________

Physician's Name ______________________

Physician's CT License Number ______________________

Telephone/Address (Prescriber Stamp) ______________________

Condition for which drug is being administered during school hours ______________________

Is child capable of self administration? ☐ Yes ☐ No

Brand Name of Drug and Strength ______________ Generic Name of Drug ______________

Is this a Controlled Substance? ☐ Yes ☐ No

Amount of drug to be administered for each dose ______________ Time(s) drug is to be administered ______________ Method of Administration ______________

Period during which medication is to be administered: ☐ School Year ☐ ______________ to ______________

Relevant side effects to be observed, if any/plan for management ______________________

______________________ **PHYSICIAN'S/PRESCRIBER'S SIGNATURE** ______________ **Date**

AUTHORIZATION OF PARENT/GUARDIAN FOR ADMINISTRATION OF ABOVE MEDICATION

School: ET, OH, PRS, PV, WES, TEMS, SWHS ______________ Grade ______________

I hereby request that the medication indicated above, as ordered by the authorized prescriber, be given to my child as follows:

☐ Administered by school personnel ☐ Self-Administered per Board of Education policy

I understand that I must supply the school with the prescribed medication in the original container, dispensed and properly labeled by an authorized prescriber, and will provide no more than a 3 month supply of said medication. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school. I give permission for the exchange of information between the prescriber and the nurse to ensure the safe administration of medication.

SPECIAL INSTRUCTIONS

1. Late arrival: ☐ give AM on arrival ☐ omit AM dose ☐ delay doses 90 min ☐ give doses on time ☐ omit dose(s)

2. Early closing: ☐ give as usual ☐ omit dose(s)

3. **Field trips:** ☐ give as usual ☐ omit dose(s)

______________________ **PARENT/GUARDIAN SIGNATURE** ______________ **Date**

______________________ Printed Name ______________ Daytime Phone Number

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VALID FOR: 2014-2015 SCHOOL YEAR

PARENTAL PERMISSION FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION PER STANDING ORDERS FROM DISTRICT MEDICAL ADVISOR

South Windsor Public Schools has standing orders from our district medical advisor for the administration of some medications for students if we have written permission from the student's parent/guardian. If you wish to allow your child to have access to the following orders, please complete this form and return it to your school nurse(s).

Student Last Name, First Name	**Date of Birth**
School: ET, OH, PRS, PV, WES, TEMS, SWHS	Grade

Please **initial** next to any of the following orders that you would like your student to have available during the school day.

Parent Initials	**Acetaminophen** (non aspirin pain reliever) may be administered to student with written parental authorization for the relief of a febrile headache, dysmenorrheal or orthodontic pain, by and at the discretion of the school nurse, using professional judgment. *Dosages to be age and/or size appropriate.
Parent Initials	**Ibuprofen** (Advil, Motrin) sent in by a parent/guardian may be administered to student with written parental authorization for the relief of dysmenorrheal or orthodontic pain, by and at the discretion of the school nurse, using professional judgment. Dosage: ____________________
Parent Initials	**Sunscreen** sent in by parents/guardians may be applied by the school nurse.
Parent Initials	**Insect Repellent** sent in by parents/guardians may be applied by the school nurse.
Parent Initials	**Cough Drops** sent in by parents/guardians may be used by students.

I understand that any medications/ items sent in from home must be in the original, properly labeled, sealed container, and item(s) will be destroyed if not picked up within one week beyond the close of school. All medications must be brought in and picked up by a legally responsible adult.

I give permission for the exchange of information between the prescriber and the school nurse necessary to ensure the safe administration of the above mentioned medications/items.

______________________________ **Parent/Guardian Signature**

______________________________ **Date**

______________________________ **PRINTED NAME**

______________________________ **Daytime Phone Number**

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 I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

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 I — 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 II — Medical Evaluation

HAR-3 REV. 4/2012

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 I 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			***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made		
Genitalia/ hernia					
Skin					

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

Student Name: ______________________ **Birth Date:** ______________ HAR-3 REV. 4/2012

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 for 7th grade entry	
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	*	*			PK and K (born 1/1/2007 or later)	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			2 doses required for K & 7th grade as of 8/1/2011	
PCV	*				PK and K (born 1/1/2007 or later)	
Meningococcal	*				Required for 7th grade entry	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

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

Exemption

Religious _____ **Medical: Permanent** _____ **Temporary** _____ **Date** _____

Recertify Date ________ Recertify Date ________ Recertify Date ________

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN

- DTaP: At least 4 doses. The last dose must be given on or after 4th birthday.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 day apart – 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after 1st birthday (Children 5 years and older do not need proof of Hib vaccination).
- Pneumococcal: 1 dose on or after 1st birthday (born 1/1/2007 or later and less than 5 years old).
- Hep A: 2 doses given six months apart-1st dose on or after 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students enrolled before August 1, 2011, 1 dose given on or after 1st birthday; for students enrolled on or after August 1, 2011 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 1-6

- DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 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. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses – the last dose on or after 24 weeks of age.
- Varicella: 1 dose on or after the 1st birthday or verification of disease*.

GRADE 7

- Tdap/Td: 1 dose of Tdap for students 11 yrs. or older enrolled in 7th grade who completed their primary DTaP series; For those students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are needed, one of which **must** be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart – 1st dose on or after the 1st birthday.
- Meningococcal: one dose for students enrolled in 7th grade.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 8-12

- Td: At least 3 doses. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine one of which should be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart or verification of disease*.

* **Verification of disease:** Confirmation in writing by a 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 nation-wide shortage of supply for such vaccine.

____

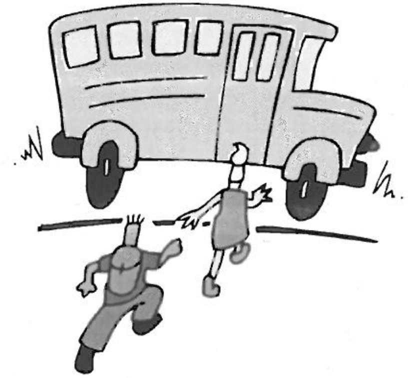
Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped *Provider* Name and Phone Number

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

IMMUNIZATION REQUIREMENTS FOR ENROLLED STUDENTS IN CONNECTICUT SCHOOLS

2014-2015 SCHOOL YEAR



PRESCHOOL

DTaP: 4 doses by 18 months
Polio: 3 doses by 18 months
MMR: 1 dose on or after 1st birthday
Hep B: 3 doses, last one on or after 24 weeks of age
Varicella: 1 dose on or after 1st birthday or verification of disease
Hib: 1 dose on or after 1st birthday
Pneumococcal: 1 dose on or after 1st birthday
Influenza: 1 dose administered each year between August 1st-December 31st (2 doses separated by at least 28 days required for those receiving flu for the first time)
Hepatitis A: 2 doses given six calendar months apart, 1st dose on or after 1st birthday

KINDERGARTEN

DTaP: At least 4 doses. The last dose must be given on or after 4th birthday
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Hep B: 3 doses, last dose on or after 24 weeks of age
Varicella: 2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease
Hib: 1 dose on or after 1st birthday for children less than 5 years old
Pneumococcal: 1 dose on or after 1st birthday for children less than 5 years old
Hepatitis A: 2 doses given six calendar months apart, 1st dose on or after 1st birthday

GRADES 1-2

DTaP/Td: At least 4 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses.
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Hep B: 3 doses, last dose on or after 24 weeks of age
Varicella: 2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease
Hepatitis A: 2 doses given six calendar months apart, 1st dose on or after 1st birthday

GRADE 3

DTaP/Td: At least 4 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses.
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Hep B: 3 doses, last dose on or after 24 weeks of age
Varicella: 2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease

GRADES 4-6

DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses.
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Hep B: 3 doses, last dose on or after 24 weeks of age

Revised 12/4/2013

	Varicella:	1 dose on or after the 1st birthday; or verification of disease
GRADES 7-10		
	Tdap/Td:	1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap
	Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
	MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
	Meningococcal:	1 dose
	Hep B:	3 doses, last dose on or after 24 weeks of age
	Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease
GRADE 11-12		
	Td/Tdap:	At least 3 doses. The last dose must be given on or after 4th birthday Students who start the series at age 7 or older only need a total of 3 doses one of which should be Tdap.
	Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
	MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
	Hep B:	3 doses, last dose on or after 24 weeks of age
	Varicella:	2 doses given at least 4 weeks apart; 1st dose on or after 1st birthday or verification of disease

Important Reminders:

- DTaP vaccine is not given on or after the 7th birthday and may be given for all doses in the primary series.
- Tdap can be given in lieu of Td vaccine for children 7 years and older unless contraindicated. Tdap is only licensed for one dose.
- Hib is not required for children 5 years of age or older.
- Pneumococcal is required for all Pre-K and K students born on or after 1/1/2007 and less than 5 years of age.
- Hepatitis A requirement for school year 2014-15 applies to all Pre-K, K, 1st and 2nd grade students born on or after 1/1/2007.
- Hep B requirement for school year 2014-2015 applies to all students in grades K-12.
  Spacing intervals for a valid Hep B series: at least 4 weeks between doses 1 and 2; 8 weeks between doses 2 and 3; at least 16 weeks between doses 1 and 3; dose 3 should not be given before 24 weeks of age.
- Second MMR for school year 2014-2015 applies to all students in grades K-12.
- If two live virus vaccines (MMR, Varicella, MMRV, Intranasal Influenza) are not administered on the same day, they must be separated by at least 28 days (there is no 4 day grace period for live virus vaccines). If they are not separated by at least 28 days, the vaccine administered second must be repeated.
- Lab confirmation of immunity is **only** acceptable for Hep B, Hep A, Measles, Mumps, Rubella, and Varicella.
- **VERIFICATION OF VARICELLA DISEASE:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.
- For the full legal requirements for school entry visit www.ct.gov/dph/cwp/view.asp?a=3136&Q=467374&PM=1

New Entrant Definition:

*New entrants are any students who are new to the school district, including preschoolers and all students coming in from Connecticut private, parochial and charter schools located in the same or another community. **All students entering kindergarten**, including those repeating kindergarten, those moving from any public or private pre-school program, even in the same school district, **are considered new entrants**. The one exception is students returning from private approved special education placements–they are not considered new entrants.

Commonly Administered Vaccines:

Vaccine:	Brand Name:	Vaccine:	Brand Name:
DTaP-IPV-Hib	Pentacel	MMRV	ProQuad
DTaP-HIB	TriHibit	PCV7	Prevnar
HIB-Hep B	Comvax	PCV13	Prevnar 13
DTaP-IPV-Hep B	Pediarix	DTaP-IPV	Kinrix
Hepatitis A	Havrix, Vaqta	Influenza	Fluzone, FluMist, Fluviron, Fluarix, FluLaval