CALIFORNIA SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent record (cumulative folder) as defined in Section 49068 of the Education Code and shall transfer with that record. Local health departments shall have access to this record in schools, child care facilities, and family day care homes.

This record must be completed by school and child care personnel from an immunization record provided by parent or guardian. See reverse side for instructions.

Student Name ______________ **Sex:** M ☐ F ☐ **Birthdate** ______________ **Place of Birth** ______________

Name of Parent or Guardian ______________

Race/Ethnicity:
- ☐ White, not Hispanic
- ☐ Hispanic
- ☐ Black
- ☐ Other: ______________

Address ______________

Telephone ______________ Daytime Nighttime

City ______________ **ZIP** ______________

VACCINE	DATE EACH DOSE WAS GIVEN					
	1st	2nd	3rd	4th	5th	Booster
POLIO (OPV or IPV)	/ /	/ /	/ /	/ /	/ /	
DTP/DTaP/DT/Td (Diphtheria, tetanus and [acellular] pertussis OR tetanus and diphtheria only)	/ /	/ /	/ /	/ /	/ /	/ /
MMR (Measles, mumps, and rubella)	/ /	/ /				
HIB (Required only for child care and preschool)	/ /	/ /	/ /	/ /		
HEPATITIS B	/ /	/ /	/ /			
VARICELLA (Chickenpox)	/ /	/ /				
HEPATITIS A (Not required)	/ /	/ /				

I. DOCUMENTATION

I certify that I reviewed a record of this child's immunizations and transcribed it accurately:

Date ______ / / ______

Staff Signature ______________

Record Presented was:
- ☐ Yellow California Immunization Record
- ☐ Out-of-state school record
- ☐ Other immunization record

Specify: ______________

II. STATUS OF REQUIREMENTS
- ☐ A. All Requirements are met.

  Date ______ / / ______
- ☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.

Exemption was granted for:
- ☐ C. Medical Reasons—Permanent
- ☐ D. Medical Reasons—Temporary
- ☐ E. Personal Beliefs

III. 7th GRADE ENTRY
- ☐ A. All Requirements are met.

  ______________ Name ______________ Date
- ☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.

  ______________ Name ______________ Date

TB SKIN TESTS	Type*	Date given	Date read	mm indur	Impression
	☐ PPD-Mantoux ☐ Other	/ /	/ /		☐ Pos ☐ Neg
	☐ PPD-Mantoux ☐ Other	/ /	/ /		☐ Pos ☐ Neg

*If required for school entry, must be Mantoux unless exception granted by local health department.

CHEST X-RAY (Necessary if skin test positive)

Film date: ______ / / ______ Impression: ☐ normal ☐ abnormal

Person is free of communicable tuberculosis: ☐ yes ☐ no

STATE OF CALIFORNIA–DEPARTMENT OF PUBLIC HEALTH

CDPH California Department of Public Health

CDPH 286 (01/14)

INSTRUCTIONS FOR SCHOOL OR CHILD CARE STAFF

1. Complete child's name and address information section, or ask parent or guardian to complete this section only. (This form is not to be sent home or given to parents to complete.)
2. School or child care personnel then fill in date (month/day/year) of each immunization the student has received from the Immunization Record presented by the parent or guardian. (If the date consists only of month and year for some doses, fill in month/xx/year; however, if either measles, rubella or mumps (or MMR) was received in the month of the first birthday, month/day/year is required.)
3. Determine if immunization requirements have been met, using the California "Immunization Requirements for Grades K–12," or "Immunization Requirements for Child Care," (available from Immunization Coordinators in local health departments), or other requirements guide.
4. Complete the Documentation and Status of Requirements box.
   A. Fill in date and your signature as the staff member who reviewed and transcribed the immunization record presented by the parent or guardian. Check which type of record was presented.
   B. If the child has met all immunization requirements, check box A and write in date.
   C. If the child has not met all requirements, check box B. Child can be admitted only if up-to-date, e.g., no immunizations due currently. The child must be followed up as indicated in the "Guide to Immunization Requirements."
   D. If a child is to be exempted for medical reasons, a doctor's written statement is required; the statement must include which immunization(s) is to be exempted and the specific nature and probable duration of the medical condition. If the medical exemption is permanent, the requirement for the designated immunization(s) is met: check box A and box C.* If the medical exemption is temporary, check box B and box D; this child must be followed up.*
   E. If a child is to be exempted for reasons of personal beliefs, the parent or guardian must present documentation consistent with Health and Safety Code Section 120365, including documentation of all other required immunizations the child has received. All requirements are met; check box A and box E.*

Applicable only in those jurisdictions where the Tuberculosis Assessment is required for school entry

Personal Beliefs Affidavit to be Signed by Parent or Guardian—Tuberculosis

I hereby request exemption of the child named on the front from the tuberculosis assessment requirement for school/child care center entry because this procedure(s) is contrary to my beliefs. I understand that should there be cause to believe that my child is infected with active tuberculosis or should there be a tuberculosis outbreak, my child may be temporarily excluded from school.

Creencias Personales: Declaración Jurada Debe ser Firmada por el Padre o la Madre o el Guardián

Solicito por la presente la dispensa de mi hijo, nombrado en el reverso, de los requisitos para la evaluación de la tuberculosis (tisis) de la entrada a la escuela ya que esta evaluación es opuesta a mis creencias. Comprendo que si hay razón para sospechar que mi hijo sufra de la tuberculosis activa o si hay un brote de la tuberculosis, mi hijo puede ser excluido de la escuela.

Signature (Firma) ______________________ Date (Fecha) ______________________

* Names of all children who are exempt should be maintained on an exempt roster for immediate identification in case of disease outbreak in the community.

CALIFORNIA SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent record (cumulative folder) as defined in Section 49068 of the Education Code and shall transfer with that record. Local health departments shall have access to this record in schools, child care facilities, and family day care homes.

This record must be completed by school and child care personnel from an immunization record provided by parent or guardian. See reverse side for instructions.

Student Name ______________ **Sex:** M ☐ F ☐ **Birthdate** ______________ **Place of Birth** ______________

Name of Parent or Guardian ______________

Race/Ethnicity:
☐ White, not Hispanic
☐ Hispanic
☐ Black
☐ Other: ______________

Address ______________

Telephone ______________ Daytime ______________ Nighttime

City ______________ **ZIP** ______________

VACCINE	DATE EACH DOSE WAS GIVEN					
	1st	2nd	3rd	4th	5th	Booster
POLIO (OPV or IPV)	/ /	/ /	/ /	/ /	/ /	
DTP/DTaP/DT/Td (Diphtheria, tetanus and [acellular] pertussis OR tetanus and diphtheria only)	/ /	/ /	/ /	/ /	/ /	/ /
MMR (Measles, mumps, and rubella)	/ /	/ /				
HIB (Required only for child care and preschool)	/ /	/ /	/ /	/ /		
HEPATITIS B	/ /	/ /	/ /			
VARICELLA (Chickenpox)	/ /	/ /				
HEPATITIS A (Not required)	/ /	/ /				

TB SKIN TESTS	Type*	Date given	Date read	mm indur	Impression
	☐ PPD-Mantoux ☐ Other	/ /	/ /		☐ Pos ☐ Neg
	☐ PPD-Mantoux ☐ Other	/ /	/ /		☐ Pos ☐ Neg

*If required for school entry, must be Mantoux unless exception granted by local health department.

CHEST X-RAY (Necessary if skin test positive)

Film date: / / Impression: ☐ normal ☐ abnormal

Person is free of communicable tuberculosis: ☐ yes ☐ no

I. DOCUMENTATION

I certify that I reviewed a record of this child's immunizations and transcribed it accurately:

Date ______ / / ______

Staff Signature ______________

Record Presented was:
☐ Yellow California Immunization Record
☐ Out-of-state school record
☐ Other immunization record
Specify: ______________

II. STATUS OF REQUIREMENTS

☐ A. All Requirements are met.
Date ______ / / ______

☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.

Exemption was granted for:
☐ C. Medical Reasons—Permanent
☐ D. Medical Reasons—Temporary
☐ E. Personal Beliefs

III. 7th GRADE ENTRY

☐ A. All Requirements are met.

______________ Name ______________ Date

☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.

______________ Name ______________ Date

STATE OF CALIFORNIA—DEPARTMENT OF HEALTH SERVICES
IMMUNIZATION BRANCH

PM 286 (1/02)

INSTRUCTIONS FOR SCHOOL OR CHILD CARE STAFF

1. Complete child's name and address information section, or ask parent or guardian to complete this section only. (This form is not to be sent home or given to parents to complete.)
2. School or child care personnel then fill in date (month/day/year) of each immunization the student has received from the Immunization Record presented by the parent or guardian. (If the date consists only of month and year for some doses, fill in month/xx/year; however, if either measles, rubella or mumps (or MMR) was received in the month of the first birthday, month/day/year is required.)
3. Determine if immunization requirements have been met, using the California "Immunization Requirements for Grades K–12," or "Immunization Requirements for Child Care," (available from Immunization Coordinators in local health departments), or other requirements guide.
4. Complete the Documentation and Status of Requirements box.
   A. Fill in date and your signature as the staff member who reviewed and transcribed the immunization record presented by the parent or guardian. Check which type of record was presented.
   B. If the child has met all immunization requirements, check box A and write in date.
   C. If the child has not met all requirements, check box B. Child can be admitted only if up-to-date, e.g., no immunizations due currently. The child must be followed up as indicated in the "Guide to Immunization Requirements."
   D. If a child is to be exempted for medical reasons, a doctor's written statement is required; the statement must include which immunization(s) is to be exempted and the specific nature and probable duration of the medical condition. If the medical exemption is permanent, the requirement for the designated immunization(s) is met: check box A and box C.* If the medical exemption is temporary, check box B and box D; this child must be followed up.°
   E. If a child is to be exempted for reasons of personal beliefs, the parent or guardian must sign and date the affidavit below. No other parents should sign this affidavit. All requirements are met; check box A and box E.*

PERSONAL BELIEFS AFFIDAVIT TO BE SIGNED BY PARENT OR GUARDIAN—IMMUNIZATION

I hereby request exemption of the child, named on the front, from the immunization requirements for school/child care entry because all or some immunizations are contrary to my beliefs. I understand that in case of an outbreak of any one of these diseases, the child may be temporarily excluded from attending for his/her protection.

CREENCIAS PERSONALES: ESTA DECLARACIÓN JURADA DEBE SER FIRMADA POR EL PADRE O LA MADRE O EL GUARDIÁN

Solicito por la presente la dispensa de mi hijo, nombrado en el reverso, de los requisitos para vacunas de la entrada a la escuela/guardería ya que algunas o todas de las vacunas son opuestas a mis creencias. Comprendo que en caso de un brote en la communidad de alguna de estas enfermedades, mi hijo puede ser excluido temporalmente de la escuela/guardería por su propia protección.

Signature (Firma) ______________________ Date (Fecha) ______________

Applicable only in those jurisdictions where the Tuberculosis Assessment is required for school entry

Personal Beliefs Affidavit to be Signed by Parent or Guardian—Tuberculosis

I hereby request exemption of the child named on the front from the tuberculosis assessment requirement for school/child care center entry because this procedure(s) is contrary to my beliefs. I understand that should there be cause to believe that my child is infected with active tuberculosis or should there be a tuberculosis outbreak, my child may be temporarily excluded from school.

Creencias Personales: Declaración Jurada Debe ser Firmada por el Padre o la Madre o el Guardián

Solicito por la presente la dispensa de mi hijo, nombrado en el reverso, de los requisitos para la evaluación de la tuberculosis (tisis) de la entrada a la escuela ya que esta evaluación es opuesta a mis creencias. Comprendo que si hay razón para sospechar que mi hijo sufra de la tuberculosis activa o si hay un brote de la tuberculosis, mi hijo puede ser excluido de la escuela.

Signature (Firma) ______________________ Date (Fecha) ______________

* Names of all children who are exempt should be maintained on an exempt roster for immediate identification in case of disease outbreak in the community.

PERTUSSIS BOOSTER IMMUNIZATION ASSESSMENT OF SEVENTH GRADE STUDENTS 20__ - 20___SCHOOL SUMMARY SHEET

PLEASE TYPE OR PRINT CLEARLY

Note: *This form may be completed online at* ***ShotsForSchool.org***

County ______________________

This school is: Public ☐ Private ☐

School Name ______________________

Public School District ______________________

Physical Address ______________________

CDS code # ______________________

City ______________ Zip __________

Mailing Address ______________________
(if different from above)

School Telephone Number (________) ______________

PERTUSSIS BOOSTER (Tdap) STATUS OF 7TH GRADE STUDENTS **This report must include every 7th grade student in this school**			
Column 1 +	**Column 2** +	**Column 3** =	**Column 4**
Pertussis (Tdap) vaccine completed	Permanent Medical Exemption to Tdap	Personal Beliefs Exemption to Tdap	Total Students Enrolled

Note: THE NUMBER OF STUDENTS IN COLUMNS 1+2+3 SHOULD EQUAL COLUMN 4, THE TOTAL STUDENTS ENROLLED.

See reverse side for instructions.

Please forward the completed report by November 1st of each school year (e.g., school year 2012-13, submit the completed report by November 1, 2012) to the California Department of Public Health Immunization Branch. Retain a copy for your school records.

Immunization Branch
California Department of Public Health
850 Marina Bay Parkway
Bldg P, 2nd floor
Richmond, CA 94804

School Staff Member Completing This Form

Name ______________________

Email ______________________

Date ______________, 20_____

Designated School Contact

Name ______________________

Email ______________________

Phone (________) ______________

HOW TO COMPLETE THE IMMUNIZATION ASSESSMENT OF SEVENTH GRADE STUDENTS SCHOOL SUMMARY SHEET *(CDPH 8259 (09/11))*

California law requires that all public and private schools with 7th grade submit an immunization assessment (Health and Safety Code, Section 120375) for the pertussis booster (Tdap) requirement. Beginning with the 2012-2013 school year, schools are to report each school year on the pertussis booster (Tdap) status of ALL students enrolled in 7th grade.

FIRST STEP: FILLING IN THE REPORTING PERIOD

Enter the school year for which you are submitting a summary report form.

SECOND STEP: FILLING IN SCHOOL INFORMATION

Enter the school's county, name, address(es), district, and telephone number in the appropriate fields. Check whether the school is public or private. Enter the school's CDS code number if it has one. Enter the name and email address of the school staff member who has completed the form and the date of completion. Enter the name, telephone number and email address of the designated school contact person.

THIRD STEP: DETERMINING STUDENTS' IMMUNIZATION STATUS

Determine the pertussis immunization status of each student in 7th grade by reviewing the California School Immunization Record, or Blue Card, (CSIR PM-286) included in the child's cumulative file, or by reviewing the electronic immunization record. A dose of any pertussis-containing vaccine (e.g. Tdap, DTaP, DTP) received on or after the 7th birthday satisfies the 7th grade pertussis booster requirement. Pertussis (Tdap) immunization is recorded on a sticker (CDPH form PM 286 S) affixed to the blue California School Immunization Record.

FINAL STEP: COMPLETING THE SCHOOL SUMMARY SHEET

Enter the number of 7th grade students into the corresponding fields in the appropriate columns, i.e., pertussis (Tdap) vaccine completed; permanent medical exemption; and personal beliefs exemption. If a field's value is 0, enter 0.

Add the number of students in Column 1, Column 2, and Column 3 and enter the total in Column 4. The number of students in Columns 1 + 2 + 3 must equal Column 4, the total number of students enrolled. Double check that all numbers are correct.

PERTUSSIS (Tdap) ASSESSMENT OF 7-12TH GRADE STUDENTS

2011-2012 SCHOOL SUMMARY SHEET

PLEASE TYPE OR PRINT CLEARLY

Note:** This form can be completed online at **ShotsForSchool.org

County ______________________

This school is: Public ☐ Private ☐

School Name ______________________

Public School District ______________________

Physical Address ______________________

CDS code # ______________________

City ______________ Zip ________

Mailing Address ______________________
(if different from above)

Tdap STATUS OF 7-12TH GRADE STUDENTS **This report must include every 7-12th grade student in this school**				
Grade	**Column 1** + Pertussis (Tdap) vaccine completed	**Column 2** + Permanent Medical Exemption to Tdap	**Column 3** = Personal Beliefs Exemption to Tdap	**Column 4** Total Students Enrolled
7				
8				
9				
10				
11				
12				

Note: FOR EACH GRADE, THE NUMBER OF STUDENTS IN COLUMNS 1+2+3 SHOULD EQUAL COLUMN 4, THE TOTAL STUDENTS ENROLLED.

Detailed instructions for completing this form are on back side of this form.

Please forward the completed report by December 1, 2011 to the California Department of Public Health Immunization Branch. Retain a copy for your school records.

Immunization Branch
California Department of Public Health
850 Marina Bay Parkway
Bldg P, 2nd floor
Richmond, CA 94804

School Staff Person Completing This Form ______________________

School Telephone Number (____) ______________ Date __________

HOW TO COMPLETE THE PERTUSSIS (Tdap) ASSESSMENT OF 7-12TH GRADE STUDENTS SCHOOL SUMMARY SHEET *(CDPH 8260)*

California law requires that all public and private schools with 7th, 8th, 9th, 10th, 11th and/or 12th grades submit a pertussis (Tdap) immunization assessment (Health and Safety Code, Section 120375). Schools are to report on the status of ALL students in 7th – 12th grades enrolled for the 2011-2012 school year.

FIRST STEP: FILLING IN SCHOOL INFORMATION

Enter the county, school name and address, school district, etc. in the appropriate fields. Check whether the school is public or private. Enter the school's CDS code # if it has one.

SECOND STEP: DETERMINING STUDENTS' IMMUNIZATION STATUS

Determine the pertussis immunization status of each student in 7th – 12th grade by reviewing the California School Immunization Record, or Blue Card, (CSIR PM-286) which must be included in the child's cumulative file. Pertussis (Tdap) immunization is recorded on a sticker (CDPH form PM 286 S) affixed to the blue California School Immunization Record.

FINAL STEP: COMPLETING THE SCHOOL SUMMARY SHEET

Complete the rows that correspond with the grades in your school. Enter the number of students for each grade level, i.e., 7th, 8th, 9th, 10th, 11th, and 12th, into the corresponding fields in the appropriate columns, i.e., pertussis booster immunization (Tdap) completed; permanent medical exemption; and personal beliefs exemption. If a field's value is 0, enter 0.

Add the number of students in Column 1, Column 2, and Column 3 and enter the total in Column 4. For each grade level, the number of students in Columns 1 + 2 + 3 must equal Column 4, the total number of students enrolled. Double check that all numbers are correct.

PERSONAL BELIEFS EXEMPTION TO REQUIRED IMMUNIZATIONS

STUDENT NAME (LAST, FIRST, MIDDLE)	GENDER ☐ M ☐ F	BIRTHDATE MONTH DAY YEAR __ __ / __ __ / __ __ __ __	TELEPHONE NUMBER
PARENT/GUARDIAN – NAME		ADDRESS	

A. AUTHORIZED HEALTH CARE PRACTITIONER LICENSED IN CALIFORNIA – FILL OUT THIS SECTION

I am a (check one): ☐ M.D./D.O. ☐ Nurse Practitioner ☐ Physician Assistant ☐ Naturopathic Doctor ☐ Credentialed School Nurse

Provision of information: I have provided the parent or guardian of the student named above, the adult who has assumed responsibility for the care and custody of the student, or the student if an emancipated minor, with information regarding 1) the benefits and risks of immunization and 2) the health risks to the student and to the community of the communicable diseases for which immunization is required in California (immunizations listed in Table below).

Signature of authorized health care practitioner

Date - within 6 months before entry to child care or school

Practitioner name, address, telephone number:

B. PARENT OR GUARDIAN – FILL OUT THESE SECTIONS

I. Check one of the boxes below:

☐ **Receipt of information:** I have received information provided by an authorized health care practitioner regarding 1) the benefits and risks of immunization and 2) the health risks to the student named above and to the community of the communicable diseases for which immunization is required in California (immunizations listed in Table below).

☐ **Religious beliefs**: I am a member of a religion which prohibits me from seeking medical advice or treatment from authorized health care practitioners. (Signature of a health care practitioner not required in Part A.)

Signature of parent or guardian

Date - within 6 months before entry to child care or school

II. AFFIDAVIT

Immunizations already received: I have provided the child care or school with a record of all immunizations the student has received that are required for admission (California Health and Safety Code §120365).

Immunizations for which exemption is requested: An unimmunized student and the student's contacts at school and home are at greater risk of becoming ill with a vaccine-preventable disease. I understand that an unimmunized student may be excluded from attending school or child care during an outbreak of, or after exposure to, any of these diseases for the protection of the student and others (17 CCR §6060). I hereby request exemption of the student named above from the required immunizations checked below because such immunization is contrary to my beliefs.

School Category	Table of Required Immunizations – Check box(es) to request exemption.
Child Care Only	☐ ***Haemophilus influenzae* type b** (Hib meningitis)
Child Care and K-12th Grade	☐ **DTaP** (Diphtheria, Tetanus, Pertussis [whooping cough]) ☐ **Hepatitis B** ☐ **MMR** (Measles, Mumps, Rubella) ☐ **Polio** ☐ **Varicella** (Chickenpox)
7th Grade Advancement (or admission at 7-12th Grade)	☐ **Tdap** (Tetanus, reduced Diphtheria, Pertussis [whooping cough])

Signature of parent or guardian

Date

The California Department of Public Health places strict controls on the gathering and use of personally identifiable data. Personal information is not disclosed, made available, or otherwise used for purposes other than those specified at the time of collection, except with consent or as authorized by law or regulation. The Department's information management practices are consistent with the Information Practices Act (Civil Code Section 1798 et seq.), the Public Records Act (Government Code Section 6250 et seq.), Government Code Sections 11015.5 and 11019.9, and with other applicable laws pertaining to information privacy.

ANNUAL IMMUNIZATION REPORT ON CHILDREN ENROLLED IN CHILD CARE CENTERS

Please Type or Print

County ______________________

Center Name ______________________

Address ______________________

City ____________ Zip Code ____________

Type of Facility

☐ Public

☐ Private

☐ Head Start

Phone No. (   ) ____________

Enrollment of children under 2 years of age ☐
(Do not include these children in the section below. Don't forget -- all these children may need additional immunizations)

NOTE: Information for this report should be obtained from the blue California School Immunization Records (PM 286) of all enrolled children. See enclosed instructions for details.

1. VACCINE DOSE SUMMARY for children ages 2 years through 4 years, 11 months (use work sheet grand totals)

Enrollment of children ages 2 through 4 years, 11 months ☐

VACCINE	0	1	2	3	4
POLIO					//////
DTP/Td/TD					
MMR			//////	//////	//////
HIB			//////	//////	//////
HEP B					//////
VARICELLA (CHICKENPOX)			//////	//////	//////

2. EXEMPTIONS:

2a. How many children are exempt from all or some immunizations for medical reasons? ____________

2b. How many children are exempt from all or some immunizations for personal beliefs? ____________

3. FOLLOW-UP:

3a. ☐ **Number of Children with Follow-up Needed.** (Those with less than 3 polio, 4 DTP, 1 MMR, 1 Hib, 3 hep B, and 1 varicella. Do not include children who have physician-documented varicella (chickenpox) disease. Include children who have not yet completed all of these doses. Do not include children under 2 years of age.)

3b. ☐ **Number of Children with No Follow-up Needed.** (This includes children who are exempt.)

3c. ☐ **TOTAL** (3a+3b = 3c) Must equal the Enrollment shown above of children ages 2 through 4 years, 11 months.

Please complete this report by October 15th unless an earlier date has been established by your local health department. Return the top copy (Yellow) of this report to the Immunization Coordinator at your **county health department.** The pink copy is for your files.

Name of person completing this form: ______________________ Date: ____________

State of California-Health and Welfare Agency

Department of Health Services

Page ______ of ______
(Side 1)

ANNUAL IMMUNIZATION ASSESSMENT REPORT OF CHILDREN ENROLLED IN CHILD CARE CENTERS

County ____________________

LINE LISTING OF IMMUNIZATION STATUS OF CHILDREN AGES 2 YEARS THROUGH 4 YEARS, 11 MONTHS

Please complete this Line Listing Report by September 30 and return to the Immunization Coordinator at your county health department.
(MAKE A PHOTOCOPY AND KEEP FOR YOUR FILES.)

Center Name ____________________ Center Address ____________________ City and Zip ____________________

Type of Facility: ☐ Public ☐ Private ☐ Head Start Phone ( ) ____________ Contact Person ____________________ Date __________

ENROLLMENT UNDER AGE 2 ____ Do not list children under age 2 or over 5 years in this report **NAME OR ID OF CHILD**	Date of Birth	Follow-up Needed	VACCINE DOSE SUMMARY (List children 2-4 years, 11 months) ENTER DATE OF EACH VACCINE RECEIVED										EXEMPT		Comments
			Polio Doses				DTP/Td Doses				MMR	*Hib**	Med	Pers	
			1	2	3	4+	1	2	3	4+					
1.															
2.															
3.															
4.															
5.															
6.															
7.															
8.															
9.															
10.															
11.															
12.															
13.															
14.															
15.															
16.															
17.															
18.															
19.															
20.															
Line List Subtotal															
Grand Total For Health Dept. Use Only															

**Hib Meningitis vaccine will be required in late 1994 or early 1995, but at this time one dose received on or after the first birthday is strongly recommended. Record only the doses given on or after the first birthday.*

DHS 8387 (Rev. 3/94)

(Side 2)

NAME OR ID OF CHILD	Date of Birth	Follow -up Needed	Polio Doses				DTP/Td Doses				MMR	Hib*	EXEMPT		Comments
			1	2	3	4+	1	2	3	4+			Med	Pers	
21.															
22.															
23.															
24.															
25.															
26.															
27.															
28.															
29.															
30.															
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42.															
43.															
44.															
45.															
46.															
47.															
48.															
49.															
50.															
Line List Subtotal															

Hib Meningitis vaccine will be required in late 1994 or early 1995, but at this time one dose received on or after the first birthday is strongly recommended. Record only the doses given on or after the first birthday.

DHS 8387 (Rev. 3/94)

State of California - Health and Human Services

Department of Health Services

For Office Use Only

ANNUAL FAMILY DAY CARE HOME IMMUNIZATION SURVEY

LIST OF CHILDREN LESS THAN 5 YEARS OLD

Please complete this form and return in enclosed envelope
to: Immunization Branch, Department of Health Services
2151 Berkeley Way, Rm 712, Berkeley, CA 94704

COUNTY: ______________

Have you ever had immunization training? YES: ☐ NO: ☐

NAME: ______________ ADDRESS: ______________ CITY: ______________ ZIP: ______

PHONE ______________ **Date this form filled out:** ______________
(Very Important!)

If you do not provide childcare at this time, please check this box: ☐

FULL/PART-TIME CHILDREN		ENTER DATE OF EACH VACCINE RECEIVED (Month/Day/Year)																Is Child
Child's First Name	Date of	Polio Doses			DTP/DTaP/DT Doses				MMR	Hib Doses				Hepatitis B Doses			Varicella	Up-to-Date
or Child's Initials	Birth	1	2	3	1	2	3	4	1	1	2	3	4	1	2	3	1	(yes/no)
1.																		
2.																		
3.																		
4.																		
5.																		
6.																		
7.																		
8.																		
9.																		
10.																		
11.																		
12.																		

State of California - Health and Human Services Agency

Department of Health Services

IMMUNIZATION ASSESSMENT OF KINDERGARTEN STUDENTS —ANNUAL REPORT

SCHOOL SUMMARY SHEET

PLEASE LEAVE BLANK

PLEASE TYPE OR PRINT CLEARLY

If information is NOT correct, please correct

County ____________________

School Name ____________________

Physical Address ____________________

City ____________ Zip ________

Mailing Address ____________________
(if different from above)

This school is: Public ☐ Private ☐

Public School District ____________________

CDS code# ____________________

NUMBER OF KINDERGARTEN STUDENTS ENROLLED THIS YEAR ☐

INSTRUCTIONS: Information for this report must be obtained from the blue California School Immunization record(PM286). This report includes every kindergarten child (or child of kindergarten age) enrolled in this School.

Instructions for filling out this form are on the back (pink copy).

If this school does not have any kindergarten students, please write "NO K THIS YR" or "NO K EVER" or "CLOSED" across the form and forward as instructed below.

IMMUNIZATION STATUS OF KINDERGARTEN STUDENTS

UNCONDITIONAL ENTRANTS

Indicate the number of kindergartners with.

1. All required immunizations and/or documented history of disease ________
2. Permanent Medical Exemptions to any immunizations ________
3. Personal Beliefs Exemptions to any immunizations ________

Note: The total of lines 1+2+3+4 should equal NUMBER OF KINDERGARTEN STUDENTS ENROLLED THIS YEAR, shown in box above.

CONDITIONAL ENTRANTS

4. Number of kindergartners who do not meet all the immunization requirements: i.e., who have not documented on or more required immunizations or who have a <u>temporary</u> medical exemption. (THESE STUDENTS MUST BE FOLLOWED UP.) ________

Of the pupils in category 4 above, please indicate the numbers <u>NOT</u> meeting the requirement for:

a. Polio ________
b. DTP / DTaP / DT ________
c. 1st Dose MMR (child has received no MMR doses) ________
d. 2nd Dose MMR (child has received only 1 MMR after 12 months of age) ________
e. Hepatitis B ________
f. Varicella (child has not received vaccine and has not had chicken pox) ________

Please forward copies of this report by October 15 :

WHITE — Immunization Branch, California Department of Health Services
2151 Berkeley Way, Berkeley, CA 94704

YELLOW — Immunization Coordinator, County Health Department

GOLD — School District copy, if a public school

PINK — School copy: retain for your files

School Staff Person Completing This Form ____________________

School Telephone Number (____) ____________ Date ________

PM 236 (3/01)

Tdap (Pertussis Booster) Requirement

Date of Tdap Immunization ___ ___ / ___ ___ / 2 0 ___ ___
MM DD YYYY

Birthdate ___ ___ / ___ ___ / ___ ___ ___ ___
MM DD YYYY

Check one:

- ☐ Tdap was given on or after 7th birthday. (Td does not meet requirement.)
- ☐ Medical exemption from physician on file.
- ☐ Tdap personal belief exemption affidavit from parent/guardian on file.

School Staff Name ______________________

Today's Date ______________________

Student Name or ID ______________________

PM 286 S (01/11)