CHATFIELD/LOPRESTI REGISTRATION PACKET 2016-2017

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SONCCA-CHATFIELD/LOPRESTI
2016-2017 REGISTRATION PACKET

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SONCCA E.I.N. # (Tax I.D. Number): 06-1155484

TO BEGIN SONCCA ON THE FIRST DAY OF SCHOOL, REGISTRATION MUST BE RECEIVED IN OUR OFFICE BY THE END OF THE BUSINESS DAY ON AUGUST 12th. ANY REGISTRATIONS RECEIVED AFTER AUGUST 12th WILL HAVE A START DATE OF SEPTEMBER 15th.

AFTER SEPTEMPER 15th AND DURING THE SCHOOL YEAR, REGISTRATION MUST BE RECEIVED IN OUR OFFICE THREE BUSINESS DAYS PRIOR TO YOUR DESIRED START DATE.

2016-2017 SONCCA-CHATFIELD/LOPRESTI REGISTRATION PACKET

PLEASE BE SURE TO READ ALL THE INFORMATION PROVIDED.
OUR FORMS ARE UPDATED EVERY YEAR.

Please Complete, Sign and Return all Registration Forms listed below with your $25.00 Registration Fee and your Final Tuition Deposit (please submit a separate check for the registration fee and the final tuition deposit) to:

SONCCA, INC.
256 Bank Street
Seymour, CT 06483

- ☐ Parent Agreement
- ☐ Registration Form
- ☐ Notification & Child Release Authorization Form
- ☐ Emergency Early Dismissal Information
- ☐ Medication Statement & Photograph Permission Form
- ☐ School Release Form
- ☐ Transportation Form Needed if SMS Student
- ☐ Grant Information Questionnaire
- ☐ Health Assessment Form

2016-2017 SONCCA-CHATFIELD/LOPRESTI PARENT AGREEMENT

Registration for: _____

As parent/guardian of the above child, I hereby request SONCCA (Seymour-Oxford Nursery & Child Care Association, Inc.) provide care for my child at the SONCCA-Chatfield/LoPresti location.

Please check appropriate days and times of enrollment.

☐ Full Time (4-5) days
☐ Part Time (1-3) days

☐ Before School
☐ After School

☐ Monday
☐ Tuesday
☐ Wednesday
☐ Thursday
☐ Friday

Registration Fee & Final Tuition Deposit:

☐ $25.00 non-refundable registration fee enclosed. Check #_____.

☐ I have enclosed the required Final Tuition Deposit of $_____, Check #_____, which is equal to 50% of one month's tuition.

I understand that this Final Tuition Deposit will be applied to my last month's tuition in June, 2017 or to my final tuition balance upon two-week written notification of withdrawal.

Tuition Payment Agreement:

I agree to pay a monthly payment of $_____, payable by the first day of the month.

I understand that if payment is not received by the 10th of the month, a late fee of $25.00 will be applied each month. I further understand that failure to submit payment in full by the 15th of the month will result in the immediate termination of services. I understand that, while SONCCA does deliver monthly statements, I will not receive an invoice and my fee is due regardless of receipt of that statement. This fee is payable by check or money order made out to: **SONCCA, Inc., 256 Bank Street, Seymour, CT, 06483**. I understand that these fees are payable regardless of the number of days my child attends and I am responsible for notifying the site and the administrative office of any changes with regard to my child's participation in the program two weeks in advance of the change.

I also understand that I must provide SONCCA with a **written notice of my intent to withdraw** prior to the 15th of the current month for a withdrawal date of the 1st of the following month and prior to the 30th of the month for a withdrawal date of the 15th of the following month. I also understand that I am responsible for the fees due to SONCCA for my child(ren) during this period. I further understand that tuition fees will continue to be assessed to my account until a written withdrawal notice is provided.

I understand that I will be liable for any and all collection fees, legal fees and court fees incurred by SONCCA in its attempt to collect all tuition and fees as agreed upon in this registration contract.

I give my permission for financial information to be shared with _____, who is responsible for partially or totally paying for my child's monthly tuition fee.

I have received a copy of the PARENT HANDBOOK, or I have read the online PARENT HANDBOOK, including the Discipline Policy and Insurance Policy, and I understand and agree to abide by the policies and procedures contained therein.

I ALSO GIVE MY PERMISSION FOR ALL OF THE FOLLOWING:

1. For the Site Supervisor or any other qualified staff member to take whatever steps may be necessary to obtain emergency medical care, if warranted. These steps may include, but are not limited to, the following:
   a. Administering emergency first aid (by State-approved, first-aid certified SONCCA personnel);
   b. Contacting the parent or guardian, either by calling them at their place of employment, or by attempting to contact them through any of the persons listed on the emergency information form (**This form MUST be kept updated!);**
   c. Contacting the child's physician or dentist;
   d. Contacting another physician or calling an ambulance, if neither a parent nor the child's physician can be reached;
   e. Accompany your child in the ambulance to the hospital emergency room you have selected, if possible; otherwise, taking your child to Griffin Hospital;
   f. Any expenses incurred will be borne by the parents.
2. For SONCCA to obtain a copy of the health record on file at the child's school.
3. For my child to use all of the playground equipment and to participate in all of the SONCCA program activities, unless exceptions are noted here: .
4. For my child to leave the school premises under supervision of a staff member for neighborhood walks or for field trips, provided that I have signed the specific permission slip for the planned activity. Means of transportation, if any, will be noted.
5. To obtain information which might enhance my child's adjustment to the SONCCA program from my child's school.
6. For my child to be included in evaluations associated with the program.

I ALSO UNDERSTAND THAT:

1. SONCCA will not be responsible for anything which may happen as a result of false information given at the time of enrollment or during the program year.
2. I am responsible for the daily signing in and signing out of my child and SONCCA will not assume responsibility for any child not signed in by a responsible adult upon arrival for the AM session or not signed in by a responsible adult when coming to the PM session via transportation other than that which the school provides.
3. Parents are expected to carry insurance for their children. SONCCA does not carry "medical payments for children" insurance. There is no medical reimbursement.

4. If both parents do not sign this page and both parents want to be allowed to pick up the child, the other parent's name must be included on the authorized pick-up page.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

*Date you would prefer your child to start: _____

(If your chosen start date cannot be accommodated, we will call.)

ADMINISTRATIVE

Date starting program:_____

☐ $25.00 Registration Check # _____ ☐ Final Tuition Deposit Check # _____

Procare _____Date _____ Billing _____Date_____

2016-2017 SONCCA-CHATFIELD/LOPRESTI REGISTRATION FORM

Child's Name: _____ ☐ Chatfield/LoPresti ☐ SMS

Address: _____ Phone: _____

Age: _____ Date of Birth: _____ Gender: _____ Grade 2016-2017: _____

MOTHER'S (Legal Guardian's) _____

Address and Phone if different from above: _____

_____ Date of Birth: _____
verification purposes

Place of Employment: _____

Business Address: _____

Business Phone: _____ Cell Phone: _____

FATHER'S (Legal Guardian's) _____

Address and Phone if different from above: _____

_____ Date of Birth: _____
verification purposes

Place of Employment: _____

Business Address: _____

Business Phone: _____ Cell Phone: _____

CHILD'S PHYSICIAN: _____ Phone: _____

Address: _____

CHILD'S DENTIST: _____ Phone: _____

Address: _____

CHILD'S DENTIST: _____

Address: _____

HOSPITAL PREFERRED: _____

Health Insurance Company: _____ Policy Number: _____

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

Below please provide an e-mail address where you would like to receive correspondence.

E-mail Address: _____

☐ **IF THERE IS ANY ADDITIONAL INFORMATION WHICH YOU BELIEVE WILL ASSIST SONCCA IN PROVIDING AN OPTIMAL EXPERIENCE FOR YOUR CHILD, PLEASE SHARE THAT INFORMATION ON A SEPARATE PIECE OF PAPER AND INCLUDE IT WITH THE REST OF THE FORM**

2016-2017 SONCCA-CHATFIELD/LOPRESTI NOTIFICATION & CHILD RELEASE AUTHORIZATION

Child's Name:____

If SONCCA cannot reach me, I authorize the following person(s) to be notified. I also authorize SONCCA to release my child to any of the following person(s). This (these) individual(s) has(have) my permission to sign him/her in or out in the event that I am unable to do so. State regulations require that at least one person other than parents be listed (at least one of the persons listed must be local, within a 10-minute drive, and available for an emergency pickup). **Please cross out and initial any blank areas.**

NAME: ____________________________ HOME PHONE: ____________
ADDRESS: ____
RELATIONSHIP:____________________ WORK/CELL PHONE:____________

NAME: ____________________________ HOME PHONE: ____________
ADDRESS: ____
RELATIONSHIP:____________________ WORK/CELL PHONE:____________

NAME: ____________________________ HOME PHONE: ____________
ADDRESS: ____
RELATIONSHIP:____________________ WORK/CELL PHONE:____________

NAME: ____________________________ HOME PHONE: ____________
ADDRESS: ____
RELATIONSHIP:____________________ WORK/CELL PHONE:____________

NAME: ____________________________ HOME PHONE: ____________
ADDRESS: ____
RELATIONSHIP:____________________ WORK/CELL PHONE:____________

NAME: ____________________________ HOME PHONE: ____________
ADDRESS: ____
RELATIONSHIP:____________________ WORK/CELL PHONE:____________

☐ **I understand that my child will be permitted to leave SONCCA ONLY with those individuals listed above, all of whom are at least sixteen years of age.**

☐ **I also understand that if both parents have not signed the forms and are not listed on this page, they will not be allowed to pick-up their child.**

____________________________ __________________
Parent/Guardian Signature Date

____________________________ __________________
Parent/Guardian Signature Date

2016-2017 SONCCA-CHATFIELD/LOPRESTI
EMERGENCY EARLY DISMISSAL INFORMATION

Teacher's Name: _____ Grade: _____

When school is canceled prior to the normal time due to inclement weather or other emergency, the school buildings are closed and the SONCCA PM Session is canceled. The SONCCA staff does not become responsible for my child, therefore:

My child, _____ should,

Please check one:

☐ walk to: ☐ be picked up by: ☐ take his/her regularly assigned bus #:_____ to:

NAME: _____

ADDRESS: _____ PHONE: _____

The school has limited telephone lines; therefore, I understand that the school will **NOT** be able to phone me or the person listed. The person listed above is willing to remain informed and contact me should such a situation occur.

Please note, only with extenuating circumstances can these plans be changed once they have been communicated to the school office. They cannot be changed on the day of the emergency.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

Administrative

One copy SONCCA file (Original copy to School)

2016-2017 SONCCA-CHATFIELD/LOPRESTI
MEDICATION STATEMENT & PHOTO PERMISSION FORM

Child's Name:_____

MEDICATION WAIVER STATEMENT:

When a child's physical form states s/he takes a medication, but the parent does not provide SONCCA with that medication, SONCCA requires a signed statement from that parent saying:

Although my child's physical form states that s/he takes medication for _____ (fill in the name of the illness), I do not feel it is necessary to provide SONCCA with the medication to be kept on site.

I understand, if the medication on the physical form is one which counteracts an emergency situation, like an asthma attack, an allergic reaction or a seizure, SONCCA requires an Action Plan signed by the child's doctor.

Parent/Guardian Signature_____

PHOTOGRAPH PERMISSION AGREEMENT:☐

☐ I give permission to SONCCA to take and use photographs of my child participating in the SONCCA program for publicity and fund development purposes, some of which may be included on the SONCCA website.

☐ I do not give permission to SONCCA (Seymour-Oxford Nursery & Child Care Association, Inc.) to take and use photographs of my child participating in the SONCCA program for publicity and fund development purposes, or to be shown on the SONCCA website.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

2016-2017 SONCCA-CHATFIELD/LOPRESTI SCHOOL RELEASE FORM

Please complete both forms - your child cannot be released from his/her classroom without parent's written permission.

I give permission for _____to be released by his/her classroom teacher to SONCCA program after school on the following days:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

(SONCCA COPY)

2016-2017 SONCCA-CHATFIELD/LOPRESTI SCHOOL RELEASE FORM

I give permission for _____to be released by his/her classroom teacher to SONCCA program after school on the following days:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

(Teacher's Copy: Parent to provide copy to teacher)

2016-2017 SONCCA-CHATFIELD/LOPRESTI
TRANSPORTATION PERMISSION FORM

Child's Name:_____

I,_____, give permission for my child,
(Parent/Guardian's Name)

_____, to be transported
(Child's Name)

from Seymour Middle School to SONCCA-Chatfield/LoPresti School at the end of the school day.

_____ _____
Parent/Guardian's Signature Date

_____ _____
Parent/Guardian's Signature Date

SONCCA
2016-2017 GRANT INFORMATION QUESTIONNAIRE

It is through the receipt of grants that SONCCA is able to provide quality care for your child at reasonable tuition rates. The following information is requested from local, state, federal, and other funding sources as a grant submission and reporting requirement. Please note, names are not required. This form will be removed from your child's file and placed in our Grant Statistics file to be used when grant applications are made. If you wish, you may remove it from the rest of the packet and send it to the office separately.

Please place a checkmark in the appropriate items and fill in all blanks appropriate:

Town: ☐ Seymour ☐ Oxford

Child's age: _____ Gender: _____ Grade as of September 2016: _____

Child's heritage:

☐ Asian ☐ African-American ☐ Caucasian ☐ Hispanic ☐ Native American

☐ Other, Please write in: _____

Family size: _____ Number of Adults: _____ Number of Children: _____

Number of parents/guardians in household: _____

Number of parents/guardians working: _____ in training: _____

Income:

☐ A: $23,850 - $32,913

☐ B: $32,913 - $47,7000

☐ C: $47,700 - $71,500

☐ D: $71,500 - $110,000

☐ E: More than $110,000

Child is cared for by:

☐ Parent(s)

☐ A "supervising adult" (grandparents, foster parents, etc.)

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

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					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

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