



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CENTRAL CONNECTICUT COAST YMCA

Summer Camp 2026 Registration & Release Forms

Member ID# _____

Camper's First Name _____ Last _____ Gender _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age entering camp yrs ___ mos ___ Grade entering in September ___

Does your child attend Public or Private School _____ Child lives with _____

Parent # 1 _____ Parent #2 _____

Home address _____ Home address _____

Email _____ Email _____

Place of Employment _____ Place of Employment _____

Employment address _____ Employment address _____

City/State/Zip _____ City/State/Zip _____

Please check which phone number you would like used as Primary Contact number:

Home Phone # () _____ Home # () _____

Cell Phone # () _____ Cell # () _____

Work # () _____ Work # () _____

If parent cannot be reached, give name and relationship of person to be called in case of an emergency

Name _____ Relationship _____

Home # () _____ Work # () _____ Cell # () _____

The YMCA is required to permit either parent to pick up the child unless the YMCA is furnished with a court order to the contrary. Please list below any persons not authorized to pick up this child and attach the original copy of the court order.

Name _____ Relationship _____

Signature of Parent/Guardian _____ Date _____



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CENTRAL CONNECTICUT COAST YMCA Summer Camp 2026 Payment Authorization

Camper's First Name _____ Last _____ Gender _____

Summer Camp Payment Agreement

I, _____, hereby authorize the Central Connecticut Coast YMCA to charge the account listed on the Monday, two weeks prior to the session start date to act as payment for Summer Camp services. I understand the final payment for each session is due no later than the Monday, two weeks before each session begins. If the session balance is not paid by that date, I am aware that my child will not be able to attend camp until the balance has been paid in full. *To set up a different payment arrangement, please reach out to the Camp Director.

Camp Fees/ Refund Policy

Camp fees are due, in full, the Monday, two weeks prior to the session start date. Deposit fees and registration fees are non-refundable and non-transferable. Session refund requests must be done in writing on a Refund Request Form a minimum of 2 weeks prior, if I wish to discontinue this service. Refunds will not be granted less than 2 weeks before the start of a session. Refunds may be issued for medical emergencies. A physicians note will be required. There is a \$10 administration fee for all refunds.

Service Fees/ Late Fees

A \$25 late camp payment fee will be applied to accounts not paid in full by the Monday, two weeks prior to the session start date. There will be a \$30 charge for any EFT or charge returned by the bank. A \$30 fee for credit card returns and returned checks will be applied to outstanding balances. These fees will be automatically drafted from the account associated with Summer Camp payments. Failure to pay this fee will jeopardize your child's enrollment in camp.

Camp Payments

I authorize my bank to honor preauthorized Electronic Funds or credit card charges against my account for Summer Camp tuition payments as indicated below. When the bank honors the EFT or credit card by charging my account, such transfer shall constitute notice of payment due and my receipt for the payment. Should any preauthorized EFT or credit card not be honored by said bank when received by them, then it is understood that the payment is to be made by me in the amount of said payment plus service charge. It is further understood that if such payment is not honored by the bank or credit card institution, then the YMCA, at its discretion, may resubmit the amount due for payment on a future date.

I choose to utilize the EFT option for payment from my Checking Savings account. A Voided Check must be attached to this form.

I choose to utilize a credit card on file at the Y. Card Type _____ Last 4 digits _____

I choose to utilize the Credit Card Payment option for monthly payments, automatically charged to my card.

Your credit card must be swiped at the YMCA Branch to save information.

Card Type American Express Discover MC Visa

I understand the financial requirements, payment obligations, refund policy, fees and deadlines as outlined.

Print Name _____ Email _____

Billing Address _____ City _____ State _____ Zip _____

Authorized Signature _____ Date _____



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WOODRUFF FAMILY YMCA
2026 Summer Camp Session Registration Form

Child's Name _____ **MEMBER ID #** _____ **Shirt Size** _____

CAMPER UNIT	Grades	WEEK 1 6/15-6/19	WEEK 2 6/22-6/26	WEEK 3 6/29-7/3	WEEK 4 7/6-7/10	WEEK 5 7/13-7/17	WEEK 6 7/20-7/24	WEEK 7 7/27-7/31	WEEK 8 8/3-8/7	WEEK 9 8/10-8/14	WEEK 10 8/17-8/21
GREENHORNS Member \$219 Program Participant \$322	K-1	<input type="checkbox"/>									
EXPLORERS Member \$219 Program Participant \$322	2-3	<input type="checkbox"/>									
PIONEERS Member \$219 Program Participant \$322	4-6	<input type="checkbox"/>									
ARCHERY CAMP Member \$275 Program Participant \$399	3-6				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
CHALLENGE CAMP Member \$275 Program Participant \$399	3-6			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>				
CREATIVE ARTS CAMP Member \$275 Program Participant \$399	2-6			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>				
STEAM CAMP Member \$275 Program Participant \$399	2-6			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
ADVENTURERS Member \$219 Program Participant \$322	7-9	<input type="checkbox"/>									
CITS (14 & 15 YRS) Member \$160 Program Participant \$265	8-9	<input type="checkbox"/>									
PRE CARE Member \$50 Program Participant \$80	All	<input type="checkbox"/>									
POST CARE Member \$60 Program Participant \$95	All	<input type="checkbox"/>									

A one-time, non-refundable registration fee of \$50 per child is due with the completed registration form

Challenge Course State

I, _____, am aware and understand that participating in activities while at Camp Wepawaug, including high ropes course, climbing wall, and challenge activities involve a potential risk of physical injury.

Parent/Guardian Signature _____

Date _____

Registration Fee (Per Child)

\$50.00

Total weeks _____ X \$50 Deposit = _____

Total due at registration _____

WOODRUFF FAMILY YMCA

631 Orange Avenue, Milford, CT 06461

P 203 878 6501 F 203 878 0619 W woodruffymca.org



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WOODRUFF FAMILY YMCA
Summer Camp 2026 Waivers

Camper's First Name _____ Last _____ Gender _____

Parent/Guardian Permission

- I hereby give permission for my child to participate in all activities, including field trips, that are part of the camp program. I understand that there are risks associated with camp activities and programs in which my child is a participant. I hold the Y Branch, the Central Connecticut Coast YMCA, its employees, representatives, agents and assigns from any and all claims whatsoever against said parties resulting from or caused by my child's participation. **Initial** _____
- I grant permission to have my child transported to one of the YMCA's other facilities in case of inclement weather **Initial** _____
- I hereby give permission for my child to be transported by the YMCA for emergency situations when the camp needs to be evacuated for the safety of the children. **Initial** _____
- I grant permission for any pictures taken of my child while at camp to be used for publicity and promotional purposes **Initial** _____
- I give permission for the YMCA Certified First-Aid staff to treat my child, if needed. I authorize the camp staff to consent to emergency treatment, under the advice of a Connecticut licensed physician, for my child when the need for such treatment is immediate and when efforts to contact me are unsuccessful. My child will be transported to the nearest emergency facility. I understand that any expense incurred, through transportation and the treatment of my child are my responsibility. **Initial** _____

Physicians Name & Number _____ Hospital of Choice _____

- I hereby give permission for the YMCA to apply sunscreen and/or bug spray to my child. I will supply sunscreen and/or bug spray for my child, as well as apply to my child prior to camp. The YMCA is NOT responsible for lost or stolen bottles of sunscreen/bug spray (please label containers) **Initial** _____
- I understand that ALL updated Physical Forms, signed by a physician, must be turned in to the camp office at the time of registration or the latest May 1st. **Initial** _____

Signature of Parent/Guardian _____ Date _____



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WOODRUFF FAMILY YMCA
Summer Camp 2026

Authorized Pick Ups

Camper's First Name _____ Last _____ Gender _____

Guardian Authorization: In order to ensure the well-being of all our participants and our ability to help you with picking up your child, please include every person that could assume the custody of your child for any unforeseen circumstances. The YMCA WILL require photo I.D. to release any child to an authorized pick up person listed on this form. I authorize the YMCA to release my child to the custody of the following people other than the Parent/Guardians listed above.

Name _____ Relationship _____ Phone _____ Phone _____
Name _____ Relationship _____ Phone _____ Phone _____
Name _____ Relationship _____ Phone _____ Phone _____

Special Social, Behavioral or Medical Needs

Does your child require special accommodations (social, behavioral, medicine)? Yes No

If you chose Yes, please note the following:

- An Individual Care Plan (ICP), completed by parent/guardian, is required by May 1st
- Authorization of Medication Forms and Care Plan provided by Physician, signed by a Physician and parent/guardian are due by May 1st
- We want to provide a positive and successful experience for all children. If your child has social, behavioral or developmental needs, please contact the Camp Director by May 1st to discuss their needs and required support.

Please provide us with any information about your child that you think would benefit the staff from knowing to help ensure a successful/safe time at camp. _____

Signature of Parent/Guardian _____ Date _____



FOR YOUTH DEVELOPMENT®
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WOODRUFF FAMILY YMCA

Summer Camp 2026 Behavior Contract for Participants, Parents, Families & Campers

Camper's First Name _____ Last _____ Gender _____

EXPECTATIONS

- Show respect by treating other children and adults the way I would want to be treated.
- Be honest, will always tell the truth about actions and feelings.
- Be a friend that others can trust
- Demonstrate caring by helping others and treating them kindly.
- Take responsibility for my own behavior and accept the consequences for my actions.
- To be free from cruel teasing and insults.
- Have a safe, calm, clean and orderly environment.
- Make mistakes without being ridiculed by others.
- Seek help from those that are there to help. Talk with Camp Staff when frustrated or feel mistreated.
- Be treated with dignity and respect by everyone.
- Use appropriate, acceptable language. Don't talk back or use obscene, threatening language or speak in an unkind manner.
- Avoid fights or verbal abuse.
- Be fair and accepting of others eager to join any activity.
- Work and play safely.
- Be kind, considerate, helpful, and respectful towards others.
- Follow directions and listen attentively while participating in activities.
- Share equipment and materials fairly and use them properly.
- Respect property, especially things that do not belong to me.
- Cooperate with others who are there to help.
- Speak up when witnessing unfairness or offensive language or behaviors of others.
- Be a good sport whether I win or lose.
- Be truthful with everyone.

EXPECTATIONS

- Report of discipline for talking back, destroying property, bullying children, disrupting the program, refusing to obey. Parent will be required to sign these reports acknowledging that they have read the report. After three reports, child and parent may be required to meet with the Camp Leadership staff.
- Letter of discipline and immediately suspended for a minimum of one day for hitting, kicking, biting, spitting, scratching, swearing, making degrading or racial remarks, or leaving the group. Parents may be required to meet with the Camp Director before the child can return to the program.
- Camp services may also be terminated if the parent is physically or verbally abusive to a staff member. It is our desire that every child enjoys his/her experience in the program.
- Participation in the Summer Camp Program may be limited or discontinued if this contract is not followed.

Some behaviors may warrant our skipping procedure depending upon the severity of the inappropriate behavior.

Parent/Guardian Signature

Child/Participant Signature

Date



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 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

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, 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	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Address (Street, Town and ZIP code)

Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	
Primary Care Provider	<input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> American Indian/ <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other	

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 1 — 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	<input type="checkbox"/> Y <input type="checkbox"/> N	Hospitalization or Emergency Room visit	<input type="checkbox"/> Y <input type="checkbox"/> N	Concussion	<input type="checkbox"/> Y <input type="checkbox"/> N	
Allergies to food or bee stings	<input type="checkbox"/> Y <input type="checkbox"/> N	Any broken bones or dislocations	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting or blacking out	<input type="checkbox"/> Y <input type="checkbox"/> N	
Allergies to medication	<input type="checkbox"/> Y <input type="checkbox"/> N	Any muscle or joint injuries	<input type="checkbox"/> Y <input type="checkbox"/> N	Chest pain	<input type="checkbox"/> Y <input type="checkbox"/> N	
Any other allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	Any neck or back injuries	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart problems	<input type="checkbox"/> Y <input type="checkbox"/> N	
Any daily medications	<input type="checkbox"/> Y <input type="checkbox"/> N	Problems running	<input type="checkbox"/> Y <input type="checkbox"/> N	High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	
Any problems with vision	<input type="checkbox"/> Y <input type="checkbox"/> N	"Mono" (past 1 year)	<input type="checkbox"/> Y <input type="checkbox"/> N	Bleeding more than expected	<input type="checkbox"/> Y <input type="checkbox"/> N	
Uses contacts or glasses	<input type="checkbox"/> Y <input type="checkbox"/> N	Has only 1 kidney or testicle	<input type="checkbox"/> Y <input type="checkbox"/> N	Problems breathing or coughing	<input type="checkbox"/> Y <input type="checkbox"/> N	
Any problems hearing	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive weight gain/loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Any smoking	<input type="checkbox"/> Y <input type="checkbox"/> N	
Any problems with speech	<input type="checkbox"/> Y <input type="checkbox"/> N	Dental braces, caps, or bridges	<input type="checkbox"/> Y <input type="checkbox"/> N	Asthma treatment (past 3 years)	<input type="checkbox"/> Y <input type="checkbox"/> N	
Family History				Seizure treatment (past 2 years)	<input type="checkbox"/> Y <input type="checkbox"/> N	
Any relative ever have a sudden unexplained death (less than 50 years old)				<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N
Any immediate family members have high cholesterol				<input type="checkbox"/> Y <input type="checkbox"/> N	ADHD/ADD	<input type="checkbox"/> Y <input type="checkbox"/> 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.	<input type="checkbox"/> Signature of Parent/Guardian	Date
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To be maintained in the student's Cumulative School Health Record

Part 2 — Medical Evaluation

HAR-3 REV. 3/2024

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 1 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 <input type="checkbox"/> No spinal abnormality		<input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made	
Genitalia/ hernia			<input type="checkbox"/> Pass <input type="checkbox"/> Fail			
Skin			<input type="checkbox"/> Referral made			

Screenings * According to Bright Future's Periodicity Schedule

*Vision Screening		*Auditory Screening		*History of Lead Level ≥3.5 µg/dL	
Type:	<u>Right</u> <u>Left</u>	Type:	<u>Right</u> <u>Left</u>	<input type="checkbox"/> No	Date
With glasses	20/ 20/	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Yes	
Without glasses	20/ 20/	<input type="checkbox"/> Referral made		Results:	
<input type="checkbox"/> Referral made				*Speech (school entry only)	
				*HCT/HGB:	

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.

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination Completed by: <input type="checkbox"/> Dentist	Visual Screening Completed by: <input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA <input type="checkbox"/> Dental Hygienist	Normal <input type="checkbox"/> Yes <input type="checkbox"/> Abnormal (Describe) <hr/> <hr/> <hr/>	Referral Made: <input type="checkbox"/> Yes <input type="checkbox"/> No
Risk Assessment	Describe Risk Factors		
<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	<input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____	<input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	

Recommendation(s) by health care provider: _____

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

Signature of health care provider	DMD / DDS / MD / DO / APRN / PA / RDH	Date Signed	Printed/Stamped Provider Name and Phone Number
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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 7th-12th grade
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	*	*				See below for specific grade requirement
Hep B	*	*	*			Required PK-12th grade
Varicella	*	*				Required K-12th grade
PCV	*					PK and K (Students under age 5)
Meningococcal	*					Required 7th-12th grade
HPV						
Flu	*					PK students 24-59 months old – given annually
Other						

Disease Hx _____

of above (Specify) Religious Exemption: Religious exemptions must meet the criteria established in Public Act 21-6: https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf .	(Date)	(Confirmed by) Medical Exemption: _____ Must have signed and completed medical exemption form attached. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf
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KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 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, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade

- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an 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 nationwide shortage of supply for such vaccine.