



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CENTRAL CONNECTICUT COAST YMCA Summer Camp Registration & Release Form

Member ID# _____

Camper's First Name _____ Last _____ Gender _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age entering camp yrs. _____ mos. _____ Grade entering in Sept. _____ Child lives with _____

Parent # 1 _____ Parent # 2 _____

Home Address _____ Home address _____

Please Check Which Phone Number You Would Like Used As Primary Contact Number

Home Phone # () _____ Home Phone # () _____

Cell Phone # () _____ Cell Phone # () _____

Work Phone # () _____ Work Phone # () _____

Parent/Guardian E-Mail Address (camp info will be sent via e-mail) _____

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

Name: _____ Relationship: _____

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

Does your child require special accommodations (social, behavioral, medicine)? Yes _____ No _____ An Individual Plan of Care for a Child and an authorization of medication form must be provided the week before the start of camp. Initials _____

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 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. I grant permission to have my child transported to one the YMCA's other facilities in case of inclement weather. I also grant permission for any pictures taken of my child while at camp to be used for publicity and promotional purposes.

Authorization for Medical Attention: 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 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 expenses incurred, through transportation and the treatment of my child, are my responsibility.

Sunscreen/Bug Spray Release: 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 every morning. The YMCA is NOT responsible for lost or stolen bottles of sunscreen/bug spray. (Please label containers).

Guardian Authorization: In order to ensure the well-being of all our campers 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 me:

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

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

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

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

Name: _____ Relationship _____

Name: _____ Relationship _____

I understand that the Central Connecticut Coast Young Men's Christian Association, Inc. (the "Parent Company") and all of its branches are a charitable organization that makes its programs and facilities available to persons only on the condition that they agree to assume full responsibility for injury and damage. Therefore in exchange for acceptance of the child in the YMCA programs, I release, on behalf of the child, myself and members of the child's family, the YMCA, the Parent Company, and officers, directors, employees and volunteers from all claims of damage or loss to the child's property and claims of personal injury or property damage caused to others by the child, including injury or damage to YMCA property or personnel. I understand the financial requirements, registration, payment obligations and deadlines as outlined in the Summer Camp Brochure.

I have read the above and agree to the terms and conditions.

Signature of Parent/Guardian _____ Date _____



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BRIDGEPORT YMCA
2021 Summer Camp Payment and Registration Information

PAYMENT INFORMATION

A \$25 non-refundable registration fee is required per camper

A \$50 non-refundable deposit is required to secure a session. *(Deposits are non-transferrable and non-refundable)*

Session must be paid in full prior to the start of each session.

All families must apply for Care 4 Kids.

Credit card returns and returned check fee is \$25.00.

Refunds may be issued for medical emergencies. (Physician notes will be required).

Failure to remit balance and signed medical form by due date will delay your child's enrollment.

The **Summer Food Program** begins Week 3. Parents must provide lunch for Week 1 and Week 2. (*refer to Day Camp Parent Handbook*)

REGISTRATION INFORMATION

Child Name: _____

Check boxes (X) that you are interested in registering your child.

Camp Shirt Size: _____

Camp Hours 8:00 am – 4:00 pm

<input type="checkbox"/>	Week 1 June 14 – June 18	Member \$166	Community Member \$195
<input type="checkbox"/>	Week 2 June 21 – June 25	Member \$166	Community Member \$195
<input type="checkbox"/>	Week 3 June 28 – July 2	Member \$166	Community Member \$195
<input type="checkbox"/>	Week 4 July 5 – July 9	Member \$166	Community Member \$195
<input type="checkbox"/>	Week 5 July 12 – July 16	Member \$166	Community Member \$195
<input type="checkbox"/>	Week 6 July 19 – July 23	Member \$166	Community Member \$195
<input type="checkbox"/>	Week 7 July 26 – July 30	Member \$166	Community Member \$195
<input type="checkbox"/>	Week 8 August 2 – August 6	Member \$166	Community Member \$195
<input type="checkbox"/>	Week 9 August 9 – August 13	Member \$166	Community Member \$195

Drop off or mail completed, signed forms to:

BRIDGEPORT YMCA

850 Park Avenue

Bridgeport CT 06604

P 203 334 5551 **F** 203 334 2847

W bridgeportymca.org



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CENTRAL CONNECTICUT COAST YMCA Summer Camp Payment Authorizations

Child's First Name _____ Last _____ Gender _____

Summer Camp Agreement (Check One)

I _____, hereby authorize the Central Connecticut Coast YMCA to charge the account listed on the 1st of each month (March, April, May, and June) in the amount of \$_____ to act as payment for Summer Camp services. I understand that final payment for each session is due no later than the Wednesday 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.

I _____, hereby authorize the Central Connecticut Coast YMCA to charge the account listed on the Wednesday before each session begins to act as payment for Summer Camp services for the following week. I understand that final payment for each session is due no later than the Wednesday 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.

I understand that I must provide a minimum of 2 weeks notice, in writing, if I wish to discontinue this service. **There will be a \$25.00 charge for any EFT or charge returned by the bank. Also a \$25.00 late payment fee will be added to the account if not paid prior to the first day of the session. These fees will be automatically drafted from my Summer Camp account.** I understand it is my responsibility to notify the YMCA of any change in address, bank account information (if utilizing bank draft for payment of summer camp) or credit card information/expiration date (if utilizing credit card for payment of summer camp).

Please print your name _____

Address _____

Email _____

Signature _____ Date _____

I authorize my bank to honor preauthorized Electronic Funds Transfers (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 (direct debit from my Checking Savings account)
Bank Name _____ Name on Account _____
Routing/Transit Number _____ Account Number _____
Authorized Signature: _____ Date: _____

I choose to utilize a credit card on file at the Y. Reference _____
Authorized Signature: _____ Date: _____

I choose to utilize the Credit Card Payment option for monthly payment (automatic direct charge to credit card)
Your Credit Card must be swiped at the YMCA Branch. Card Type American Express MC Visa
Card Holder Name _____
Card Holder Address _____
Authorized Signature: _____ Date: _____

2021

SUMMER CAMP ONLY

Attach voided check here for EFT Accounts



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Bridgeport YMCA Summer Camp
2021 Summer Camp Transportation Permission Form

I hereby give permission for my child, _____, for emergency situations when the camp needs to be evacuated for the safety of the children.

In the event of an emergency and I cannot be reached please call:

_____ at _____
(Emergency Contact) (Phone Number)

I prefer my child to be taken to _____ hospital and in the event that my child requires emergency medical attention the following physician should be notified.

(Physician's Name and number)

Signature of Parent/ Guardian

Date



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CENTRAL CONNECTICUT COAST YMCA

Summer Camp Behavior Contract for Participants, Parents, Families and Campers

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 toward 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 behavior of others.
- Be a good sport whether I win or lose.
- Be truthful with everyone.

CONSEQUENCES

- Letter of discipline for talking back, destroying property, bullying children, disrupting the program, refusing 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 PROCEDURES DEPENDING UPON THE SEVERITY OF THE INAPPROPRIATE BEHAVIOR.

CENTRAL CONNECTICUT COAST YMCA

I've received and read the Central Connecticut Coast YMCA Day Camp Safety Plan and will follow procedures as stated.

Parent/Guardian Signature

Child/Participant Signature

Date



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**CENTRAL CONNECTICUT COAST YMCA
Minor Participant Waiver, Release, Indemnification of All Claims & Covenant
Not to Sue**

PLEASE READ CAREFULLY. THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS AND IS LEGALLY BINDING. BY SIGNING THIS AGREEMENT, YOU ARE RELEASING CENTRAL CONNECTICUT COAST YMCA INC. FROM ALL LIABILITY AND FOREVER GIVING UP ANY CLAIMS THEREFORE.

Assumption of Risk

I, in my legal capacity as parent/guardian of the minor named below ("Minor"), acknowledge and agree that any use of Central Connecticut Coast YMCA Inc. facilities, services, equipment and premises ("Facilities") and any participation in Central Connecticut Coast YMCA Inc. programs and activities ("Programs") comes with inherent risks including, but in no way limited to: (1) moderate and severe personal injury, (2) property damage, (3) disability, (4) death, and (5) sickness or disease. I voluntarily, for myself and Minor, accept and assume full responsibility for these risks as well as any and all other risks of the use of Facilities and participation in Programs. I agree that I have full knowledge of the nature and extent of all such risks and am not relying on all such risks being described in this document.

Waiver, Release, Indemnification & Covenant Not to Sue

In consideration of Minor's use of Facilities and participation in Programs I, in my legal capacity as parent/guardian of Minor, agree on behalf of myself and Minor that Central Connecticut Coast YMCA Inc., its officers, directors, agents, employees, volunteers, insurers and representatives ("Releasees") will not be liable for any personal injury, property damage, disability, death, sickness or disease incurred by Minor, however occurring including, but not limited to, the negligence of Releasees. I understand that Minor and I will be solely responsible for any loss or damage, including personal injury, property damage, disability, death, sickness or disease sustained from the use of Facilities and participation in Programs.

I further agree, in my legal capacity as the parent/guardian of Minor, on behalf of Minor, myself, and any and all legal successors and proxies, to release and **HEREBY DO RELEASE, WAIVE AND COVENANT NOT TO SUE** Releasees from any causes of action, claims, suits, liabilities or demands of any nature whatsoever including, but in no way limited to, claims of negligence, which Minor, myself, and any and all legal successors and proxies may have, now or in the future, against Releasees on account of personal injury, property damage, disability, death, sickness, disease or accident of any kind, arising out of or in any way related to the use of Facilities or participation in Programs, whether that participation is supervised or unsupervised, however the injury or damage occurs, including, but not limited to, the negligence of Releasees.

In further consideration of the use of Facilities and participation in Programs, I, in my legal capacity as parent/guardian of Minor, agree on behalf of myself and Minor to **INDEMNIFY AND HOLD HARMLESS** Releasees from any and all causes of action, claims, demands, losses, suits, liabilities or costs of any nature whatsoever, including claims of negligence, arising out of or in any way related to the use of Facilities and participation in Programs.

Minor Name (Print Clearly) _____

Parent/Guardian Signature _____

Parent/Guardian Name (Print Clearly) _____

Date _____

06/05/2020



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CENTRAL CONNECTICUT COAST YMCA

CONNECTICUT OFFICE OF EARLY CHILDHOOD (OEC) INFORMED CONSENT FORM REQUIRED FOR LICENSING

This form applies to YMCA Staff, Volunteers and Parents of children enrolled at a youth camp during the COVID-19 declared emergency.

I hereby attest that I have been informed of the following pertaining to the coronavirus:

- People who are 65 years and older and people of any age who have serious underlying medical conditions or are at higher risk for severe illness from COVID-19 are recommended to stay at home. A list of medical conditions associated with a higher risk for severe illness from COVID-19 can be found in CDC's guidance.¹ Individuals and families should consult their healthcare provider to determine whether they have medical conditions that place them at risk.
- Staff and children living in households with individuals who are 65 years and older OR have higher risk for severe illness from COVID-19 are recommended to stay home.

Signature of Staff or Parent/Guardian

Printed Name

Child's Name (if a Parent/Guardian)

Date

¹ Includes chronic lung disease or moderate to severe asthma, serious heart conditions, immunocompromised (cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications), severe obesity (body mass index [BMI] of 40 or higher), diabetes, chronic kidney disease undergoing dialysis and liver disease. Individuals should consult their healthcare provide to determine whether they have medical conditions that place them at increased risk for severe illness from COVID-19.

05/29/2020



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 physi-

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

Part II — Medical Evaluation

HAR-3 REV. 4/2017

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 <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					
Skin					

Screenings

*Vision Screening	*Auditory Screening	History of Lead level ≥ 5µg/dL <input type="checkbox"/> No <input type="checkbox"/> Yes	Date
Type: <u>Right</u> <u>Left</u>	Type: <u>Right</u> <u>Left</u>		
With glasses 20/ 20/	<input type="checkbox"/> Pass <input type="checkbox"/> Pass	*HCT/HGB:	
Without glasses 20/ 20/	<input type="checkbox"/> Fail <input type="checkbox"/> Fail	*Speech (school entry only)	
<input type="checkbox"/> Referral made	<input type="checkbox"/> Referral made	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
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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) _____ (Date) _____ (Confirmed by) _____

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

**Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.
 Medical exemptions that are temporary in nature must be renewed annually.**

Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

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.