

DISTRITO ESCOLAR INDEPENDIENTE 196
Escuelas de Rosemount-Apple Valley-Eagan
Educar a nuestros estudiantes para que alcancen todo su potencial

Número de serie 501.5.5.1.1P Adoptado Junio 2014 Revisado _____

Título **Notificación de seguimiento de los requisitos de la Ley de inmunización para alumnos de la Educación Temprana**

Fecha _____

Estimado padre/madre/tutor de _____,
escriba el nombre del alumno en letra de imprenta

A. Su hijo(a) debe estar al día con todas las vacunas obligatorias o proporcionar documentación de exención, **a fin de permanecer en la escuela.** No tenemos registro de las siguientes inmunizaciones:

___ DTaP	___ Varicela
___ Polio	___ Neumocócica (2 a 24 meses)
___ MMR	___ Hepatitis A
___ Hib	___ Hepatitis B

B. Complete una de las cuatro opciones que figuran más abajo y entregue la documentación correspondiente a la enfermera escolar:

- Una vez que la inmunización indicada más arriba haya sido aplicada, escriba la fecha (mes, día, año) de la inmunización en el Formulario de Inmunización de Educación Temprana, que figura en el reverso de este documento, firme donde se indica y devuélvalo a su enfermera escolar; **o**
- Si su hijo ha recibido por lo menos una serie de inmunizaciones y va a completar las mismas dentro de los próximos ocho meses, el médico debe indicarlo así y debe firmar el Formulario de Inmunización de Educación Temprana, que figura en el reverso de este documento; luego devuelva el documento a su enfermera escolar; **o**
- Si su hijo(a) no va a recibir la inmunización debido a una contraindicación médica o evidencia de inmunidad demostrada por laboratorio, usted debe darle a la enfermera escolar, una declaración firmada por un médico (puede usar la declaración que figura en el reverso de este documento), **o**
- Si su hijo(a) no recibe la inmunización debido a motivos de creencias y de conciencia, usted debe darle a la enfermera escolar una declaración notarial, firmada por el padre/madre/tutor (puede usar la declaración que figura en el reverso de este documento).

C. Si usted cumple con cualquiera de los criterios de elegibilidad de Vacunas para Niños de Minnesota (Minnesota Vaccines for Children, MnVFC), puede llamar a Salud Pública del Condado de Dakota (Dakota County Public Health) (952-891-7999) para recibir vacunaciones a precio reducido (Es posible que las vacunas para niños que alcancen los criterios enumerados a continuación sean gratuitas):

- Usted no tiene seguro;
- Usted está inscripto en la Asistencia Médica de Minnesota (Minnesota Medical Assistance, MA), en Cuidados Médicos de Minnesota (Minnesota Care, MnCare) o en el Programa de Asistencia Médica Prepaga (Prepaid Medical Assistance Program, PMAP);
- Usted es un aborigen americano o nativo de Alaska o,
- Usted tiene un seguro de salud que no cubre el costo de la vacuna.

D. Presente prueba de cumplimiento de la ley de inmunización del estado, a la enfermera escolar. Llame a la enfermera escolar si tiene alguna duda respecto de las inmunizaciones para su hijo. Agradecemos su atención oportuna a este tema.

Enfermera escolar oficial del _____ Distrito escolar _____

Early Childhood Immunization Form

Must be on file **before** a child attends any early childhood programs*

Name _____

Birthdate _____

Date of Enrollment _____

Minnesota law requires children enrolled in early education programs to be immunized against certain diseases or file a legal medical or conscientious exemption.

Parent/Guardian:

You may attach a copy of the child's immunization history to this form OR enter the MONTH, DAY, and YEAR for all vaccines your child received. Enter MED to indicate vaccines that are medically contraindicated including a history of disease, or laboratory evidence of immunity and CO for vaccines that are contrary to parent or guardian's conscientiously held beliefs.

Sign or obtain appropriate signatures on reverse. Complete section 1A or 1B to certify immunization status and section 2A to document medical exemptions (including a history of varicella disease) and 2B to document a conscientious exemption.

Additionally, if a parent or guardian would like to give permission to the early education program to share their child's immunization record with Minnesota's immunization information system, they may sign section 3 (optional).

For updated copies of your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

*Early childhood programs are defined as programs that provide instructional or other services to support children's learning and development and:

- Serve children from birth to kindergarten.
- Meet at least once a week for at least six weeks or more during the year.

This includes but not limited to early childhood family education (ECFE), early childhood special education (ECSE), school readiness programs, and other public and private preschool and pre-kindergarten programs.

Type of Vaccine	DO NOT USE (✓) or (✗)	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
Required (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.)						
Diphtheria, Tetanus, and Pertussis (DTaP, DTP) • 3 doses during 1st year (at 2-month intervals) • 4 th dose at 12-18 months • 5 th dose at 4-6 years <i>Indicate vaccine type: DTaP or DTP</i>						5th dose not required if 4th dose was given on or after the 4th birthday
Polio (IPV, OPV) • 2 doses in the first year • 3 rd dose by 18 months • 4 th dose at 4-6 years				4th dose not required if 3rd dose was given on or after the 4th birthday		
Measles, Mumps, and Rubella (MMR) • Required for children 15 months and older • 1 st dose on or after 1 st birthday • 2 nd dose at 4-6 years						
Haemophilus influenzae type b (Hib) • 2-3 doses in the first year • 1 dose required after 12 months or older • For unvaccinated children 15-59 months, 1 dose is required • Not required for children 5 years or older						
Varicella (chickenpox) • Required for children 15 months and older • 1 st dose on or after 1 st birthday • 2 nd dose at 4-6 years						
Pneumococcal Conjugate Vaccine (PCV) • Required for children age 2 - 24 months • 3 doses in the first year • 4 th dose after 12 months • At least 1 dose is recommended for children age 24-59 months in child care						
Hepatitis B (hep B) • 2-3 doses in the first year • 3 rd dose (final dose) by 18 months						
Hepatitis A (hep A) • 2 doses separated by 6 months for children 12 months and older						
Recommended						
Rotavirus (2-3 doses between 2 and 6 months)						
Influenza (annually for children 6 months or older)						

Instructions, please complete:

Box 1 to certify the child's immunization status

Box 2 to file an exemption (medical or conscientious)

Box 3 to provide consent to share immunization information (optional)

1. Certify Immunization Status. Complete A or B to indicate child's immunization status.

<p>A. Children who are 15 months or older: For children who are 15 months or older and who have received all the immunizations required by law for early childhood programs: I certify that the above-named child is at least 15 months of age and has completed the immunizations which are required by law for child care.</p> <p>_____ Signature of Parent / Guardian OR Physician / Nurse Practitioner / Physician Assistant / Public Clinic</p> <p>_____ Date</p>	<p>B. Children who are younger than 15 months: For children who are younger than 15 months OR have not received all required immunizations: I certify that the above-named child has received the immunizations indicated. In order to remain enrolled this child must receive all required vaccines within 18 months from initial enrollment date. The dates on which the remaining doses are to be given are:</p> <p>_____ Signature of Physician / Nurse Practitioner / Physician Assistant / Public Clinic</p> <p>_____ Date</p>
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2. Exemptions to Immunization Law. Complete A and/or B to indicate type of exemption.

<p>A. Medical exemption: No child is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a child to receive a medical exemption, a physician, nurse practitioner, or physician assistant must sign this statement: I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was laboratory confirmed (for varicella disease see * below). List exempted immunization(s):</p> <p>_____ Signature of physician/nurse practitioner/physician assistant</p> <p>_____ Date</p> <p><small>*History of varicella disease only. In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in _____ (year)</small></p> <p>_____ Signature of physician/nurse practitioner/physician assistant (If disease occurred before September 2010, a parent can sign.)</p>	<p>B. Conscientious exemption: No child is required to have an immunization that is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations may endanger the health or life of the child or others they come in contact with. In a disease outbreak, children who are not vaccinated may be excluded in order to protect them and others. To receive an exemption to vaccination, a parent or legal guardian must complete and sign the following statement and have it notarized: I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s):</p> <p>_____ Signature of parent or legal guardian</p> <p>_____ Date</p> <p>Subscribed and sworn to before me this: _____ day of _____ 20____</p> <p>_____ Signature of notary (A copy of the notarized statement will be forwarded to the commissioner of health.)</p>
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3. Parental/Guardian Consent to Share Immunization Information (optional):

Your child's early childhood program is asking your permission to share your child's immunization documentation with MIIC, Minnesota's immunization information system, to help better protect children from disease and allow easier access for you to retrieve your child's immunization record. You are not required to sign this consent; it is voluntary. In addition, all the information you provide is legally classified as private data and can only be released to those legally authorized to receive it under Minnesota law.

I agree to allow early childhood program personnel to share my child's immunization documentation with Minnesota's immunization information system:

 Signature of parent or legal guardian

 Date