

INDEPENDENT SCHOOL DISTRICT 196
Rosemount-Apple Valley-Eagan Public Schools
Educating our students to reach their full potential

Series Number 501.5.5.1P Adopted January 2004 Revised June 2014

Title Notification of Immunization Law Requirements for Incoming
Early Childhood Students

Date: _____

Dear parent/guardian of an early childhood student,

A. Minnesota law requires ONE of the following in order to attend school:

- A month-day-year record of required immunizations, signed and submitted by parents;
- A signed statement from a physician or clinic stating the child has had at least one dose of each vaccine and is in the process of completing the series, or
- A notarized statement of conscientious objection or a physician's signature stating medical exemption to vaccination.

B. To help insure the health of all children, state law requires that a child birth to five years of age (pre-kindergarten) must have the following immunizations in order to enroll or remain enrolled in school:

- | | |
|---------|------------------------------|
| • DTaP | • Varicella |
| • Polio | • Pneumococcal (2-24 months) |
| • MMR | • Hepatitis A |
| • Hib | • Hepatitis B |

The vaccine dose requirement will be dependent on the age of the child at the time of their enrollment in the class. Refer to the Early Childhood Immunization Form for specific guidelines.

C. If you meet any one of the following Minnesota Vaccines for Children (MnVFC) eligibility criteria, you may call Dakota County Public Health (952-891-7999) to receive low-cost vaccinations (There may be no charge for the vaccine for children meeting the criteria listed below):

- You are uninsured;
- You are enrolled in Minnesota Medical Assistance (MA), Minnesota Care (MnCare) or Prepaid Medical Assistance Program (PMAP);
- You are an American Indian or Alaskan Native, or
- You have health insurance that does not cover the cost of the vaccine.

D. Submit proof of compliance with the state immunization law to the school nurse prior to the first day of class for your child. Call the school nurse if you have any questions regarding immunizations for your child.

School District Official _____

School Nurse

B.M. Reilly RN, LSN

Immunization Form

Enter the dates for each vaccine your child has received to date. Specify the month, day and year of each dose such as 01/01/2010.

Name _____

Birthdate _____

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months			12 - 24 months			At Kindergarten			At 7th grade			At 12th grade		
Hepatitis B															
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)															
<i>Haemophilus influenzae</i> type b (Hib)															
Pneumococcal (PCV)															
Polio															
Measles, Mumps, Rubella (MMR)															
Chickenpox (varicella)															
Hepatitis A															
Tetanus, Diphtheria, Pertussis (Tdap)															
Meningococcal (MCV4)															

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

- Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
 - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
 - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
- Sign or get the signatures needed for the back of this form.
 - Document medical and/or non-medical exemptions in section 1.
 - Verify history of chickenpox (varicella) disease in section 2.
 - Provide consent to share immunization information (optional) in section 3.

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name _____

1. Document a medical and/or non-medical exemption (A and/or B).

Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
<i>Haemophilus influenzae</i> type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: _____ Date: _____
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me on _____ (date) by _____ (name of parent or guardian)

Notary Stamp



Notary Signature: _____

STATE OF MINNESOTA, COUNTY OF _____

Signature: _____ Date: _____
(of health care practitioner*)

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year _____

My signature below means that I confirm that this child does not need chickenpox vaccine because:

- I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.
- I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: _____ Date: _____
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

- 3. Consent to share immunization information:** This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:
 - Provide easier access for you and your school to check immunization records, such as at school entry each year.
 - Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.
- Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.
- I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: _____ Date: _____
(of parent/guardian)