Registration Form for School Year 2022-2023
August 24th 2022– June 9th 2023

Child's First/Last Name: _____
Child's Birthdate: _____ Age at Start of Program: __

Welcome to Little Farmers! Please note the following scheduling requirements:
All two and three-year-olds must meet a three-half day minimum. After three months of enrollment, one of their half days will become a full day. You're welcome to register them for half or full days and as many as you'd like if you feel they'll do well! All four- and five-year-olds have a three full day schedule requirement. If your child turns four years old mid-school year, please note that all three of their days will become full days if they aren't already.

Cost of the Program
Full Day Program: Monday-Thursday 8:00 - 4:00 ($56/day), Fridays 8:00-2:00 ($45/day)
Even though we only operate until 2:00 on Fridays, you may still use Fridays as a full day to meet age scheduling requirements
Half Day Program: Monday-Friday 8:00-12:00 ($35/day)

Please select the days you would like for your child's schedule below.
Please note that we do not visit the farm on Fridays (due to limited time)

Monday	Half Day (8:00-12:00) __	Full Day (8:00-4:00) __
Tuesday	Half Day (8:00-12:00) __	Full Day (8:00-4:00) __
Wednesday	Half Day (8:00-12:00) __	Full Day (8:00-4:00) __
Thursday	Half Day (8:00-12:00) __	Full Day (8:00-4:00) __
Friday	Half Day (8:00-12:00) __	Full Day (8:00-2:00) __

If choosing the minimum scheduling requirements for a two/three year old, please state with day will become a full day after three months:
_____

Registration Fee: For new and re-enrolling students, Parents or Guardians agree to pay a $100 non-refundable annual registration fee (per family). Checks should be made out to "Little Farmers". Registration fees are not applied towards tuition.
Today's Date of Submission: _____ Check # _____ OR Check here if paying with cash _

Parent/Guardian Name: _____

Email Address: _____

Phone Number: _____

In order to secure your child's spot, we'll need this registration form, a signed enrollment contract and deposit. Please make a copy of all form for your records.

Little Farmers Child Care Center Enrollment Contract School Year 2022-2023

I wish to enroll my child _____, in Little Farmers Child Care Center (LFCCC) for the academic year 2022-2023. I understand and agree to abide by the following school policies.

1. **Enrollment in the Program** – Parents or Guardians agree that the child shall be enrolled in this Preschool Program for the school year 2022-2023. The child will have a set schedule of days that the parent has selected on the Registration Form.

2. **Non-refundable Registration Fee** - For new and re-enrolling students, Parents or Guardians agree to pay a $100 non-refundable annual registration fee (per family, not child). Payment of the Registration Fee is due at the time this Enrollment Contract is received by LFCCC and does not guarantee Enrollment at LFCCC. Confirmation of acceptance into the program will be communicated via email within one week of receiving this contract.

3. **Tuition Payments**: Parents or Guardians agree to pay for tuition prior to their child's attendance via cash, check or Bill Pay. We send invoices monthly and you are expected to make a payment in full at the beginning of each month. We can set up a weekly payment plan as needed. Please visit the Parent Handbook for more information regarding payment.

Parents or Guardians pay for the child's spot in this program regardless of illness, vacation, snow days, personal reasons, and the center's days of holiday closures. All families enrolled agree to pay a $40 fee/day for days of Holiday closure. Please note the following days of closure that you will be responsible for: 9/5, 11/24, 11/25, 12/26-12/30, 5/29. We factor the total amount of holiday closure fees divided by our ten-month school year into your monthly bill so that it is paid over time. If you withdraw from the program early, your remaining balance for holiday closure will be added to your bill that will be paid at the time of the fourteen-day withdrawal notice.

Families who are enrolled full time (5 full days per week) will only pay half of their normal tuition during 12/26-12/30. Full time families also receive 5 "free days" during the school year. These free days exclude holiday closure, snow days and sick days. A three week notice in writing must be given to use your free days.

COVID policies will be updated as new information emerges. Families agree to abide by the changing covid financial policies as they develop.

4**. Early Withdrawal. Termination of Contract.**

a. Early Withdrawal from program: Early withdrawal of the Student from LFCCC program requires written notification with a fourteen-day advance notice. All tuition payments must be paid in full at the time of the notice, this includes the remaining fourteen days that the child will be in attendance.
b. Termination: LFCCC reserves the right to terminate this Enrollment Contract and dis-enroll Students from LFCCC programs with or without notice. Parents or Guardians agree and understand that termination of this Enrollment Contract and disenrollment of the Student from LFCCC's programs does not change the payment provisions set forth above. Parents or Guardians may be asked to withdraw the Student if LFCCC determines, in its sole discretion, that the program is not meeting the Student's needs or that the Student's presence is having an adverse effect on the program.

5. **Field Trip Consent** - During the course of the day, children will walk next door to the Sharon Family Farm (the adjacent property) M-TH every other week. Children will remain supervised by their assigned teacher and we will comply with state ratio regulations while at the farm. By signing below, you give us your permission to transport your child via our school bus to the farm (weather pending) and allow your child to visit the farm at any time during school hours.

Parent/Guardian Signature _____Date _____

Little Farmers Child Care Center Registration Packet

Staple/Glue a picture of your child here.

Child's Information

Child's Full Name: _____

Date of Birth: _____

Home Address: _____

Town/State/Zip Code: _____

Date of Admission: _____

Parent/Guardian Information

Full Name: _____

Home Address: _____ Town/City: _____ State: _____ Zip Code: _____

Cell Phone Number: _____ Second Phone # if unemployed: _____

WorkPlace: _____ Workplace Phone #: _____

WorkPlace Address: _____

Email Address: _____

Marital Status: _____ Relationship to Child: _____

Parent/Guardian Information

Full Name: _____

Home Address: _____ Town/City: _____ State: _____ Zip Code: _____

Cell Phone Number: _____ Second Phone # if unemployed: _____

WorkPlace: _____ Workplace Phone #: _____

WorkPlace Address: _____

Email Address: _____

Marital Status: _____ Relationship to Child: _____

Child's Physician Office: _____

Child's Physician: _____

Office Address: _____ **Phone #:** _____

Photo Release (Initial your preference):

_____I grant Little Farmers Child Care Center my permission to use my child's picture on Facebook, their website, displays throughout the center or on newsletters.

____ I **do not** grant Little Farmers Child Care Center permission to use my child's picture for any purpose.

Pick Up Personnel Form

We use a security system for attendance and check/out procedures. Please follow the directions below to create your account. Using a computer will best assist you in completing the account.

1. Go to www.go.kidcheck.com and click on "Create Your KidCheck Account"
2. Under the "Guardians" tab, please add any people allowed to pick up your child. Please also include yourself and the second guardian. You will not pop up on the pickup list if you do not add yourself here. You should also have yourself listed under the "My Profile" Tab. You should include everyone's first name, last name and phone number.
3. Next, go to the "Kids" tab and please fill in their first name, last name, birthdate, gender and a picture. Please leave the "Medical/Allergy" info box completely empty if your child does not require medication or have allergies.
4. Download the KidCheck application on your phone. Upon arrival, you'll sign your child in by entering your phone number into our iPAD (or a staff member will). It's best that you do not create a pin for your account.

Anyone picking up can download the app if they want, but please only have ONE person create an account
You can Enable Text Messages to get notifications when your child is check in/out

Please list the individuals who are allowed to pick up your child from our center. Whoever is listed on the first page of this registration packet under parent/guardian are already on our pickup list – you do not need to write your names again below.

Pick Up Person:

Full Name: _____

Phone Number: _____

Relationship to Child: _____

Pick Up Person:

Full Name: _____

Phone Number: _____

Relationship to Child: _____

Pick Up Person:

Full Name: _____

Phone Number: _____

Relationship to Child: _____

Pick Up Person:

Full Name: _____

Phone Number: _____

Relationship to Child: _____

In case of an emergency or late pick up, I give my permission to Little Farmers Child Care Center to contact any of the above individuals.

Parent/Guardian Signature: _____ Date: _____

Emergency Consent and Allergy Form

Little Farmers Child Care Center has my permission to obtain emergency medical treatment for my child when I cannot be reached or if a delay in reaching my child would be dangerous for him/her. I understand that I assume all financial responsibility for any treatment or injuries sustained by my child while she was in Little Farmers Child Care Center's care.

Parent/Guardian Signature: _____ Date: _____

Please review our Emergency Policies in our Parent Handbook. Should we need to provide emergency care to your child, the medical staff will receive this form upon their upon arrival so that the hospital knows your child's allergies and medications. An ambulance would bring your child to the closest hospital with CCMC being the preference of care.

Please list below all of your child's allergens and the severity of each. (Please list all allergies whether they are food, environmental, or allergies to medications):

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any medications your child takes, the dosage and duration in which it's taken.

1. _____
2. _____
3. _____
4. _____
5. _____

If your child requires medication you will need to request the Authorization of Medication Form and the Care plan Form.

Please print and staple or glue a picture of the front and back of your child's insurance card below.

Front of Insurance Card	Back of Insurance Card

Financial Management Plan

Please note the following scheduling requirements. If your child is three years old, there is a three half-day minimum. After three months of enrollment, one of those days will become a full day. You can register for more than just the minimum if you feel that your child will do well! If your child is four or five years old, there is a three full-day minimum.

Full Day Program:

Monday-Thursday 8:00 - 4:00 ($56/day), Fridays 8:00-2:00 ($45/day)

Even though we only operate until 2:00 on Fridays, you may still use Fridays as a full day to meet age scheduling requirements

Half Day Program:

Monday-Friday 8:00-12:00 ($35/day)

Registration Fee: For new and re-enrolling students, Parents or Guardians agree to pay a $100 non-refundable annual registration fee. Checks should be made out to "Little Farmers". Registration fees are not applied towards tuition.

By signing this form, you understand that you are financially responsible for all tuition fees aligned with the schedule you have selected for your child. You understand that there must be a minimum of a 30-day notice in writing in order to make any changes to your child's schedule should you need to deduct days (school year only). You may add days to your child's schedule based on our availability at any time.

Withdrawal Policy: If you need to withdraw your child from the program, you must give us a written two-week notice. You are responsible for the tuition due up until that two-week mark.

Please outline below whom is responsible for payment of tuition and fees. Please tell the director if there will be split tuition payments or if the tuition payment is the responsibility of an adult other than the parents/guardians. Tuition is always due prior to attendance. Payments may be made weekly, biweekly or monthly via check or cash. Checks are made out to "Little Farmers". You could also set us up as a Bill Pay with your online banking so that checks are mailed directly from your bank.

Email Addresses for Invoicing

Parent Agreement:

I agree to comply with the above policies and will pay my child's tuition prior to attendance.

Parent Signature Date

Parent Consent Form

Please initial next to each item.

COVID Acknowledgements

_____ I have read through all of the policies pertaining to children and teachers becoming ill and agree that I understand each item. I have thoroughly read through the COVID guidelines and understand the sanitation procedures that have put into place.

_____ I agree to wear a face covering during pick up and drop off. I will also communicate with anyone else picking up my child that they comply with wearing a mask during these times as well.

_____ I understand what I am financially responsible for should the center need to close due to COVID.

_____ I agree to not hold Little Farmers Child Care Center responsible if my child contracts COVID or any other illness during their time at school.

_____ I understand that my child must receive all of their age appropriate vaccinations in order to attend this program.

Financial Acknowledgements

_____ I agree to always pay tuition prior to my child's attendance and I understand what I am financially responsible for in terms of days of center closure as well as my child's absence due to illness.

Behavior Acknowledgement

_____ I have reviewed the behavior policies, how misbehavior is handled and the behavior incident report sections of the Parent Handbook and expressed any questions I may have regarding these policies with the director. I understand that my child may be released from the program at any time if the director feels the program is not a good fit for my child. I understand that this program involves live farm animals. I am confident that my child is able to comply with directions given by staff and will be capable of treating all of the animals nicely. I understand that if my child is unable to comply with the rules of the barn or have been found to be mistreating the animals in any way, they may be dismissed from the program upon the incident.

Liability Agreement

_____ By registering your child at Little Farmers Child Care Center (LFCCC), you agree not to hold LFCCC or Sharon Family Farm liable for any injury or illness your child may receive while at the farm. We take all of the precautions that we possibly can to ensure your child's safety and health. You agree that you understand our guidelines for farm sanitation and animal interactions. By initialing, you agree to assume any risk, take full responsibility and waive any claims of personal injury or illness while you or your child visit the Sharon Family Farm's barn.

Field Trip Consent

_____ By initialing, you are giving LFCCC consent to take your child to the Sharon Family Farm at any time during their scheduled time with us via our school bus.

I have carefully reviewed Little Farmers Child Care Center's Parent Handbook, Registration Information, and any other additional forms provided to me and agree to comply with all of the information I've been given. I understand that the policies regarding covid may change based on the status of the pandemic and I agree to comply with the changing policies or withdraw with proper notice if I'm in disagreement. I also agree that the information that I have provided on the registration forms are filled out to the best of my knowledge and includes everything the center should know about my child. My spouse/significant other/ and any other party responsible for my child has also read through all of the information and also agrees to comply with the polices put into place.

Parent's 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, 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	❑ Black, not of Hispanic origin
Primary Care Provider	❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ 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	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 2 — 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 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					
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

Part 3 — Oral Health Assessment/Screening

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	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ Yes ❑ No

Risk Assessment	**Describe Risk Factors**	
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____	❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ 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

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 7/2018

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 the1st 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 the1st 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.

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number