Registration Form ~ School Year 2020~2021

Welcome to Little Farmers! Please note the following scheduling requirements. If your child is three years old, there is a two 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 your child will do well! If your child is four or five years old, there is a three full~day minimum.

Child's Full Name: ___________________________ Child's Birthdate: ____________ Age at Start of Program: __

Full Day Program:

Monday~Thursday 8:00~4:00 ($51/day), Fridays 8:00~2:00 ($42/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 ($33/day)

Please select the days you would like for your child's schedule below.

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) __**

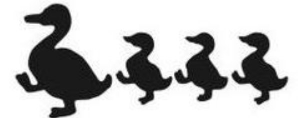
If your child is starting as a three~year~old, please state which one of their half days will become a full day after three months of enrollment if you're selecting the minimum program requirements: ____________________

If your child turns four years old mid~school year, please state which day you would like to add to their schedule if you're selecting the minimum program requirements: __________________________ Please note that when your child turns four, all three days will be full days.

Registration Fee: For new and re~enrolling students, Parents or Guardians agree to pay a $50 non~refundable annual registration fee. Checks should be made out to "Little Farmers". Registration fees are not applied to tuition.

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 this form for your records.

*Updated Form 2/28/2020

Little Farmers Child Care Center Enrollment Contract
School Year 2020-2021

I wish to enroll my child _________________________, in Little Farmers Child Care Center (LFCCC) for the academic year 2020-2021. 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 2020-2021. 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 $50 non-refundable annual registration fee. 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. 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. You may pay via check, cash, or you may set us up as a "Bill Pay" using your online banking (you will not need to enter our account number to do this, just our street address) to have payments mailed to us. 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. Please budget the following days of center closure into your payment schedule. The center will be closed on: Labor Day (9/7), Thanksgiving Day and the day after (11/26, 11/27), December Break (12/24, 12/25), New Years Day (1/1), and Memorial Day (5/31). You only pay for the days of closure in which your child would have been in attendance. The only time tuition is refunded is if a child is hospitalized or is out sick for 5 consecutive scheduled days.
*For families who register for four or more full days, you will only be charged for half of your tuition during Christmas break.

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 for any reason. 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 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) where they will interact with farm animals. Children will remain supervised by their assigned teacher and we will comply with state ratio regulations while at the farm. By signing below, you are giving us permission to allow your child to visit the Farm at any time during the day.

Parent/Guardian Signature ______________________________________ Date ____________
Parent/Guardian Signature ______________________________________ Date ____________
Director's Signature ______________________________________ Date ____________

Little Farmers Child Care Center
Registration Packet

STAPLE PHOTO OF CHILD HERE

Eye Color _______
Hair Color ______ Height ____
Weight_____

Child's Information

Child's Full Name: ____________________
Date of Birth: ____________________
Address: ____________________
City/Town: ____________________ State: ________
Date of Admission: ____________________

* If you are a working parent, you must provide a phone number for your place of work.

Parent/Guardian 1:

Full Name: ____________________
Home Address: ____________ Town/City: ____________ State: ______ Zip Code: ____________
Cell Phone: ____________________
Second Contact Number: ____________________
Email Address: ____________________
Place of Work: ____________ Work's Phone Number: ____________
Marital Status: ____________________
Relationship to Child: ____________________

Parent/Guardian 2:

Full Name: ____________________
Home Address: ____________ Town/City: ____________ State: ______ Zip Code: ____________
Cell Phone: ____________________
Second Contact Number: ____________________
Email Address: ____________________
Place of Work: ____________ Work's Phone Number: ____________
Marital Status: ____________________
Relationship to Child: ____________________

Child's Physician: ____________________
Child's Physician's Name: ____________________
Physicians Office Address: ____________________
Physician's Phone Number: ____________________

Pick Up Personnel & Security Software

We use a security/check in software called "KidCheck". Please use a computer to complete the following directions.

1. Please go to www.go.kidcheck.com and click on "Create Your Kid Check Account".
2. Under the "Guardians" tab, please list any people who are allowed to pick up your child. Under this tab, you MUST **include yourself and a second guardian** (if applicable). We know it says not to add yourself under the Guardian tab, but I am asking that you do. You should have yourself listed under the "My Profile" tab and the "Guardians" Tab. You must include a picture of everyone, their first and last name and their phone number. * We should have pictures of all pick up personnel.
3. Under the "Kids" tab, please fill in their first and last name, birthdate, gender and include a good picture. Please leave the "Medical/Allergy Info" Box completely EMPTY if your child does not require any special needs/health concerns. Do not type anything in the box at all if not applicable, otherwise your child will pop up on our allergy list. **Do not** write "none" or "n/a".
4. Download the KidCheck application on your smartphone. When you arrive for drop off, you will check your child in on our iPAD check in station OR from the "KidCheck" application on your phone (from your car). Your child is then electronically assigned a unique 4-digit code. You must turn "Enable Text Messages" under the settings in your KidCheck account to receive check in notifications. Whoever is checking children should at least be listed as a Guardian on the child's account. All you and they have to do, is type your phone number into the check in iPAD, hit the green arrow, select your child's box, assign them to their room that day, then hit the green arrow. That's it! If you choose to do it from your phone, the steps are laid out for you on the website. On your phone, you can click on "guardian receipts" to get that 4-digit code. All we need is to see your license or the code at pick up time.
5. **Only one person should create an account for a child.** Do not have your pickup personnel or second guardian create an account for the child.

We will also have a hard copy of your alternative pick up list on hand should our Internet service be down. Any person you list below (don't include yourself below, I will already have put your names down on the hard copy), should also be listed on your child's KidCheck profile under the "Guardians" Tab.

PICK UP 1:	**PICK UP 2:**
First & Last Name:	First & Last Name:
Relationship to Child:	Relationship to Child:
Phone Number:	Phone Number:
PICK UP 3:	**PICK UP 4:**
First & Last Name:	First & Last Name:
Relationship to Child:	Relationship to Child:
Phone Number:	Phone Number:

In case of an emergency or change of pick up plans, I give permission to any of the above individuals to be contacted and my child may be released to any of them.

Parent/Guardian signature: ______________________ Date: __________

Emergency Medical Consent 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. Please review our Emergency Policies in your Parent Handbook. Your child's file, which includes this form, will be given to emergency medical staff upon their arrival.

Medical Information

Preferred hospital/treatment center: ____________________
My child is taking the following medications: ____________________
My child has been confirmed to be allergic to the following: ____________________

Please list any existing medical conditions, allergies, or special needs your child may have.

____
____
____
____

Severity of Allergies:

____
____

Medication currently being taken and dosage:
1. ____________________
2. ____________________
3. ____________________

If your child has medication that needs to be taken at the center, you must request and complete:

- Medical Authorization Form for each medication
- Care Plan (completed by parents and staff)

I understand that I assume all financial responsibility for any treatment or injuries sustained by my child while he/she is in childcare.

Signature of Parent or Guardian: ____________________ Date ____________

Financial Management Plan

School Year Rates & Registration Requirements

We offer a full day preschool program that runs 8:00-4:00 Monday-Thursday and 8:00-2:00 on Fridays. We also offer a half day program Monday-Friday which runs 8:00-12:00. You may drop off and pick up your child at any time within those time frames.

Rates:

Full Day Program: Monday-Thursday (8:00-4:00) $51/day, Fridays (8:00-2:00) $42/day

Half Day Program: Monday-Friday (8:00-12:00) $33/day

If your child is three years old, there is a two 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 your child will do well! If your child is four or five years old, there is a three full-day minimum.

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 thirty-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 schedule based on availability at any time. Should you withdraw your child from the program, there is a thirty-day notice in writing and you are responsible for tuition during that time frame.

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 your child's attendance. Payments may be made weekly, biweekly or monthly via check or cash only. Checks are made out to "Little Farmers". You can also set us up as a "Bill Pay" with your online banking. You'll just need to type in our address to have payments mailed each month.

Parent Signature: ______________________ Date: ____________

Name: ______________________ Email Address: ______________________

Name: ______________________ Email Address: ______________________

<u>Photo Release Form</u>

This form is for permission to display photos of your child. With your permission, we will take and use pictures of your child to display throughout the facility, in our newsletters, on our website, on our Facebook page. This is a great way to show parents and new families what we are doing at the center.

Please indicate below if we may use your child's photograph for the uses mentioned above and return this form to the center with at the time of registration.

_______ I grant permission for Little Farmers Child Care Center to use my child's photograph for the uses listed above.

_______ **I do not** give my permission to Little Farmers Child Care Center to use my child's photograph for any use.

Child's Name: ____

Parent's 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 or have a partial closure 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.

Financial Acknowledgements

______ I agree to always pay tuition prior to my child's attendance.

______ 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 or any other reason.

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 child/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 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.

Child(ren)'s Full Name: ______________________________

Parent's Full Name: ______________________________

Parent's Signature: ______________________________ Date: ______________

PARENT CHECKLIST

- Registration Packet
- Health Assessment reflecting up to date vaccinations and physical
- Registration Form/Contract and deposit
- Medications (if applicable) must be up to date with proper paperwork
- A pair of overalls and boots
- Two changes of clothes
- Water Bottle
- Kidcheck Account www.go.kidcheck.com
- Sunscreen (depending on season)

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance?	Y	N	If your child does not have health insurance, call **1-877-CT-HUSKY**
Does your child have dental insurance?	Y	N	
Does your child have HUSKY insurance?	Y	N	

* 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	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

All medications taken in child care programs require a separate ***Medication Authorization Form*** *signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name ______________________ Birth Date ____________ (mm/dd/yyyy) Date of Exam ____________ (mm/dd/yyyy)

❑ 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.

*HT______in/cm______% *Weight______lbs.______oz /______% BMI____/_____% *HC______in/cm______% (Birth – 24 months) *Blood Pressure________/ _____ (Annually at 3 – 5 years)

Screenings

*Vision Screening	*Hearing Screening	*Anemia: at 9 to 12 months and 2 years
❑ EPSDT Subjective Screen Completed (Birth to 3 yrs) ❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment) Type: Right Left With glasses 20/ 20/ Without glasses 20/ 20/ ❑ Unable to assess ❑ Referral made to: ____________	❑ EPSDT Subjective Screen Completed (Birth to 4 yrs) ❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment) Type: Right Left ❑ Pass ❑ Pass ❑ Fail ❑ Fail ❑ Unable to assess ❑ Referral made to: ____________	*Hgb/Hct: | *Date *Lead: at 1 and 2 years; if no result screen between 25 – 72 months History of Lead level ≥ 5µg/dL ❑ No ❑ Yes
*TB: High-risk group? ❑ No ❑ Yes Test done: ❑ No ❑ Yes Date: ________ Results: ____________ Treatment: ____________	*Dental Concerns ❑ No ❑ Yes ❑ Referral made to: ____________ Has this child received dental care in the last 6 months? ❑ No ❑ Yes	*Result/Level: *Date Other:

*Developmental Assessment: (Birth – 5 years) ❑ No ❑ Yes **Type:**

Results:

*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 an ***Asthma Action Plan***
❑ Rescue medication required in child care setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: ____________________
Epi Pen required: ❑ No ❑ Yes
History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source
If yes, please provide a copy of the ***Emergency Allergy Plan***

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II

Seizures ❑ No ❑ Yes: Type: ____________

Other Chronic Disease: ____________________

❑ This child has the following problems which may adversely affect his or her educational experience:
❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior

❑ This child has a developmental delay/disability that may require intervention at the program.

❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:*____________________

❑ No ❑ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.

❑ No ❑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

❑ No ❑ Yes This child may fully participate in the program.

❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

____

❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

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

Child's Name: ______________________________ **Birth Date:** ________________ REV. 3/2015

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) ______________________________

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Influenza						
Tdap/Td						

Disease history for varicella (chickenpox) ______________________________

(Date) (Confirmed by)

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

†Recertify Date _________ †Recertify Date _________ †Recertify Date ________

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born on or after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

____

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