DEUTSCHE SCHULE GERMAN SCHOOL WASHINGTON D.C.

8617 Chateau Drive • Potomac, MD 20854 • ph: 301. 365.4400 • fax: 301.365.3905 • mail@dswash.org • www.dswashington.org

GESUNDHEITSUNTERLAGEN

An Eltern und Erziehungsberechtigte:

Um Ihr Kind an der Deutschen Schule Washington anzumelden, **benötigen** Sie Folgendes:

- Das anhängende Formular (Health Inventory), ausgefüllt und unterschrieben von einer Ärztin/einem Arzt oder einer/einem Certified Nurse Practitioner nach erfolgter medizinischen Untersuchung. Das Formular besteht aus drei Teilen:
    - **Teil 1** ist die **Erklärung zum Gesundheitsstand** des Kindes, die von den **Eltern/Erziehungsberechtigten ausgefüllt und unterschrieben werden muss**;
    - **Teil 2** ist das **Gesundheitszeugnis**, das **von einer Ärztin/einem Arzt oder einer/einem Nurse Practitioner ausgefüllt und unterschrieben** werden muss.
    - **Teil 3** ist die **Erklärung zum Wettkampfsport**, die ebenfalls **von den Eltern/Erziehungsberechtigten ausgefüllt und unterschrieben wird**. Falls Ihr Kind im Laufe des Schuljahres an Wettkämpfen mit anderen Schulen teilnehmen möchte, ist dieses Formular erforderlich.
    - **Falls eine Sportlerin/ein Sportler seit der letzten ärztlichen Untersuchung eine signifikante Verletzung, Erkrankung oder Operation hatte, muss ein ärztliches Attest vorgelegt werden, das der Sportlerin/dem Sportler erlaubt, wieder an Wettkämpfen teilzunehmen.** Bitte füllen Sie Teil 3 vor dem Arztbesuch aus, falls Ihr Kind an schulischen Wettkämpfen teilnehmen soll.

Bitte beachten Sie, dass die oben genannten Unterlagen bei der ersten Anmeldung, sowie mit dem Eintritt in die Schuleingangsstufe (SES), Klasse 5, Klasse 9 und bei Veränderungen im Gesundheitszustand des Schülers der Schülerin erneut vorgelegt werden müssen.

- Alle Schülerinnen und Schüler der Deutschen Schule Washington müssen **einen Nachweis über Schutzimpfungen** gegen ansteckende Kinderkrankheiten erbringen. Die **Maryland Immunization Certification form (Form DHMH 896)** muss ausgefüllt und unterschrieben werden, **bevor** Ihr Kind am Unterricht teilnimmt. Bitte lassen Sie alle Impfungen, die Ihr Kind bereits erhalten hat von Ihrer Ärztin/Ihrem Arzt bzw. Ihrer/Ihrem Nurse Practitioner in dieses Formular eintragen. Weiterhin muss dieses Formular aktualisiert werden, wenn Ihr Kind weitere altersentsprechende Impfungen erhält. Eine Kopie des aktualisierten Formulars muss jeweils in der Schule abgegeben werden, wo es in die Akte des Kindes aufgenommen wird.

Die Informationen zum Gesundheitsstand werden ausschließlich Angestellten der Gesundheitsabteilung und Angestellten der Schule zugänglich sein, die ein begründetes erzieherisches Interesse an Ihrem Kind haben.

Im Interesse des schulischen Erfolges Ihres Kindes, stellen Sie bitte sicher, dass alle Teile der Gesundheitsunterlagen und der Nachweis zu den Schutzimpfungen rechtzeitig bei der Schule eingehen. Falls Sie keinen Zugang zu einer Ärztin/einem Arzt oder einer/einem Nurse Practitioner haben oder Ihr Kind einen individuellen Gesundheitsplan oder Behandlung braucht, wenden Sie sich bitte an die Schulverwaltung und/oder an unsere Schulkrankenschwester.

HINWEIS: Diese Gesundheitsunterlagen gelten ausschließlich für die Klassen SES bis 12. Für den Kindergarten gibt es besondere Formulare.

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HEALTH INVENTORY

To Parents or Guardians:

In order for your child to enroll at the German School Washington, the following are **required**:

- A **physical examination** by a physician or certified nurse practitioner must be completed before admittance and the attached physical examination form, referred to as "Health Inventory," must be completed to meet this requirement. The form consists of 3 parts:
  - **Part 1** is the **Health Assessment**, which must be **completed and signed by the parent/guardian**;
  - **Part 2** is the **Health Evaluation**, which must be **completed and signed by a physician/nurse** practitioner; and
  - **Part 3** is the **Interscholastic Athletics form**, which is also **completed and signed by the parent/guardian**. If your child is going to play any sports at any time during the school year, this form is required. **A letter from a physician or nurse practitioner giving an athlete permission to participate in interscholastic athletics is required when he/she has experienced a significant injury, illness, or surgery since the last medical evaluation.** Please complete Part 3 prior to seeing the physician or nurse practitioner if your child will be participating in interscholastic athletics.

Please note that new Health Inventory forms are required at the time of first enrollment as well as prior to entering the School Entry Level (SEL), Grade 5, Grade 9 and if there is any change in the student's medical history.

- **Evidence of immunizations** against common childhood communicable diseases is mandatory for all students enrolled at the German School Washington. A **Maryland Immunization Certification form (Form DHMH 896) must be completed** before your child can attend classes. Please have your physician/nurse practitioner transcribe any immunizations your child may have already received onto this form. This form must also be updated as your child continues to receive age-appropriate immunizations as mandated and a copy of the updated form must be brought to the school to be placed in the child's file.

The Health information on this form will be available only to those health and education personnel who have a legitimate educational interest in your child.

In order to assist your child in gaining the most from his/her educational experience, please assure that all parts of the Health Inventory and Immunization Records are completed by the due date provided by the school. If you do not have access to a physician or nurse practitioner, or if your child requires a special individualized health plan/procedure, please feel free to contact the front office and/or our school nurse.

NOTE: This Health Inventory form is used for grades SEL-12 ONLY. There is a separate form for Preschool.

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TEIL 1 ERKLÄRUNG ZUM GESUNDHEITSSTAND -- Von den Eltern/Erziehungsberechtigten auzufüllen
PART 1 HEALTH ASSESSMENT – To be completed by parent/guardian

_____ _____ _____
Name des Schülers (Nachname, Vorname)/ **Student Name (Last, First Middle)** *Geburtstag*/**Date of Birth** *Klasse*/**Grade**

_____ _____
Adresse (Straße, Stadt, Staat, PLZ)/**Address (Street, City, State, Zip)** *Telefonnummer*/**Phone Number**

_____ _____
Erziehungsberechtigte/r 1 / **Parent/Guardian 1** *Erziehungsberechtigte/r 2* / **Parent/Guardian 2**

_____
Ärztin/Arzt/Nurse Practitioner Name & Adresse / **Physician/Nurse Practitioner Name & Address**

_____
Zahnärztin/Zahnarzt Name & Adresse / **Dentist Name & Address**

_____
Andere medizinische Versorgung (falls es keine gibt, bitte "keine" eintragen)/**Other sources of health care (If none, write "none")**

***ERKLÄRUNG ZUM GESUNDHEITSSTAND DER SCHÜLERIN/DES SCHÜLERS* / ASSESSMENT OF STUDENT'S HEALTH**

Nach Ihrem besten Wissen, hat Ihr Kind irgendwelche Probleme, die das schulische Lernen beeinträchtigen, Grund zur Sorge bereiten könnten oder Angestellten der Schule bekannt sein sollten? Bitte kreuzen √ Sie im Folgenden jeweils "Ja" oder "Nein" an.
To the best of your knowledge, does your child have any problems that may affect his/her learning in school, cause any concern and/or are important for school staff to know? Please check √ "Yes", or "No" for each of the following.

	Ja/**Yes**	*Nein*/**No**	*Bemerkungen*/**Comments**
Allergien (Medikamente, Lebensmittel, Insekten)- Reaktion beschreiben **Allergies (Drugs, Food, Insects)-Describe Reaction**			
Asthma/**Asthma**			
Verhaltensauffälligkeiten/**Behavior or Emotional Problems**			
Geburtsfehler/**Birth Defects**			
Blasenprobleme/**Bladder Problems**			
Blutungsneigung/**Bleeding Problems**			
Verdauungsrobleme/**Bowel Problems**			
Zerebrale Kinderlähmung/**Cerebral Palsy**			
Gehirnerschütterung/**Concussion (Head Injury)**			
Diabetes/**Diabetes**			
Gehörprobleme oder Taubheit/**Ear Problem or Deafness**			
Augen- oder Sichtprobleme/**Eye or Vision Problems**			
Herzprobleme/**Heart Problems**			
Krankenhausaufenthalte (wann, wo)/**Hospitalization (When, Where)**			
Bleivergiftung/**Lead Poisoning**			
Einschränkungen bei Aktivitäten/**Limits on Activity**			
Medikamente/**Medication**			
Meningitis/**Meningitis**			
Frühgeburt/**Prematurity**			
Krampfanfälle/**Seizures**			
Sichelzellenanämie/**Sickle Cell Disease**			
Sprachfehler oder störung/**Speech Problem**			
Operationen/**Surgery**			

Falls Sie die Gesundheit Ihres Kindes mit einer/einem Schulangestellten oder einer/einem Angestellten im Gesundheitsbereich der Schule besprechen möchten, kreuzen Sie bitte die esntsprechende Funktion an. **If you would like to discuss your child's health with school or school health personnel, please check title**: ☐ *Schulkrankenschwester*/**School Nurse** ☐ *Lehrer/Lehrerin*/**Teacher** ☐ *Counselor*/**Counselor** ☐ *Schulleiter*/**Principal**

Hiermit erkläre ich mich mit einem vertraulichen und diskreten Gebrauch von Teil 2, dem ärztlichen Gesundheitszeugnis, zum Zwecke der gesundheitlichen und schulischen Versorgung meines Kindes in der Schule einverstanden. **I give permission for confidential and discreet use of Part 2, Health Evaluation completed by the physician/nurse practitioner, to meet my child's health and educational needs in school.**
*(Bitte kreuzen Sie an/***Please check**) ☐ *Ja*/**Yes** ☐ *Nein*/**No**

_____ _____
Unterschrift, Eltern/Erziehungsberechtigte/r / **Signature, Parent/Guardian** *Datum*/**Date**

WICHTIG: *Vereinbaren Sie einen Termin für eine ärztliche Untersuchung Ihres Kindes; besprechen Sie die obenstehenden Informationen mit der Ärztin/dem Arzt oder der/dem Nurse Practitioner. Lassen Sie nach der Untersuchung Teil 2 ausfüllen und geben Sie die Unterlagen bei der Schule ab.*
IMPORTANT: Schedule an appointment for a medical examination of your child; share the above information with the physician or nurse practitioner, have him/her complete Part 2 after the examination and then return the form to the school.

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PART 2 HEALTH INVENTORY

-- To be completed by physician/nurse practitioner –

1. Does this child have (a) health condition(s) which may require EMERGENCY ACTION while she/he is at school (e.g., seizures, asthma, insect sting allergy, bleeding problem, heart problem)? If "Yes", please describe.

☐ No ☐ Yes _____

_____

2. Is this child on long-term technology assistance? ☐ No ☐ Yes _____

3. Is there any evidence for concern in the areas listed below? Indicate the results of your examination by checking the appropriate box.

CONCERN

Health Area	Yes	No	Not Evaluated	**Health Area**	Yes	No	Not Evaluated
Vision	☐	☐	☐	Adjustment	☐	☐	☐
Hearing	☐	☐	☐	Nutrition	☐	☐	☐
Speech/Language	☐	☐	☐	Physical/Illness/Impairment	☐	☐	☐
Development	☐	☐	☐	Immunodeficiency	☐	☐	☐
Attention Deficit/Hyperactivity	☐	☐	☐	Lead Poisoning	☐	☐	☐

Please explain all "yes" answers. Include recommendations for referral and treatment.

_____

_____

_____

_____

_____

4. Immunizations given on this visit: ☐ DPT/Td #_____; ☐ Polio #_____; ☐ MMR #_____; ☐ Other_____

5. Tuberculin Test: Results ☐ Positive ☐ Negative _____ ____/____/____ _____ _____ _____/____ _____ ____/____/____
Type Date (most recent) Height Weight BP Pulse Date Taken

6. Is the student on long-term medication? If yes, please describe.

☐ No ☐ Yes _____
(German School Washington *Authorization to Administer Prescribed Medication* Form must be completed for in-school administration)

7. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.

☐ No ☐ Yes _____

_____

8. Medical evaluation of students for participation in interscholastic athletics. May this student participate in the supervised activities listed below that are **NOT CROSSED OUT**?

☐ No ☐ Yes ☐ Not Applicable

Basketball	Golf	Lacrosse	Table Tennis
Badminton	Gymnastics	Soccer	Track/Field
Cross Country	Handball	Softball	Tennis
Field Hockey	Indoor Track	Swimming	Volleyball

Other: (specify) _____

If you would like to discuss this student's health with school or school health personnel, check title below.

☐ School Nurse ☐ Teacher ☐ Counselor ☐ Principal

Student Name (type/print) _____ has had a complete history and physical examination at our office and has no evident health problem except as noted above.

_____ _____-_____-_____ _____ ___/___/___
Physician/Nurse Practitioner (Print) *Phone Number* *Original Signature, Physician/Nurse Practitioner* *Date*

IMPORTANT: Maryland Immunization Certification is required by law. Please complete Form DHMH 896.

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TEIL 3 WETTKAMPFSPORT – Von Eltern und Sportlern auszufüllen
PART 3 INTERSCHOLASTIC ATHLETICS – To be completed by parent and sports candidate

*Name des Schülers/***Student Name:**_____
*Nachname/***Last** *Vorname/***First** **Middle**

*FÜR SCHÜLERINNEN UND SCHÜLER, DIE AN SPORTWETTKÄMPFEN TEILNEHMEN/***FOR STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS**

Bitte kreuzen Sie im Folgenden jeweils "Ja" oder "Nein" an. Erläutern Sie all bejahenden Antworten in der Spalte "Bemerkungen", inclusive Namen und Daten wenn angebracht. **Please check "yes" or "no" for each of the following questions. Explain all "yes" answers in the "Comments" column. Include names and dates when appropriate.**

	*Ja/***Yes**	*Nein/***No**	*Bemerkungen/***Comments**
Gibt es irgendwelche Gründe, aufgrund derer diese Schülerin/dieser Schüler nicht an allen Sportarten teilnehmen sollte? **Do you know of any reason why this individual should not participate in all sports?**			
Ist diese Schülerin/dieser Schüler in Laufe des letzten Jahres von einer Ärztin/einem Arzt angewiesen worden, sportliche Aktivitäten einzuschränken? **Has the individual been advised by a physician during the past year to restrict activity?**			
Hatte diese Schülerin/dieser Schüler jemals eine Operation? **Has the student ever had surgery?**			
War oder hatte die Schülerin/der Schüler jemals: **Has the student ever:**			
*im Krankenhaus?/***been hospitalized?**			
*bewusstlos?/***been unconscious?**			
*ohnmächtig?/***fainted?**			
*häufig Kopfschmerzen?/***had frequent headaches?**			
*Krampfanfälle?/***had convulsions?**			
Taubheitsgefühle oder Kribbeln im Gesicht, in den Armen, Beinen, oder Füßen? **had numbness or tingling of face, arms, hands, legs, or feet?**			
Schmerzen im Brustbereich?/ **had chest pain?**			
*Kurzatmigkeit?/***had shortness of breath?**			
*vergrößerte Leber order Milz?/***had enlarged liver or spleen?**			
*Schwächeanfälle oder Übelkeit bei hohen Temperaturen?/***become weak or ill when exposed to high temperatures?**			
*Hatte die Schülerin/der Schüler jemals:/***Has the student ever had:**			
*eine Kopfverletzung?/***head injury?**			
*eine Genickverletzung?/***neck injury?**			
*Rückenschmerzen?/***Back pain?**			
*Schultergelenksprengung oder ausgerenkte Schulter?/***shoulder separation or dislocation?**			
*einen verstauchten Fuß?/***ankle sprain?**			
*Kniebeschwerden (inklusive Knorpelverletzungen)?/***knee trouble (including torn cartilage)?**			
*Dislokation der Kniescheibe?/***knee cap dislocation?**			
*Knochenbrüche?/***broken bone or fracture?**			
*gezerrte Bänder oder gerissene Sehnen?/***pulled ligament or ruptured tendon?**			
*geschwollene, ausgerenkte oder schmerzende Gelenke?/***swollen, dislocated, or painful joints?**			
*gravierende Muskelverletzungen oder –risse?/***serious muscle injuries or ruptures?**			
Leidet die Schülerin/der Schüler unter einem vollständigen Verlust oder einer erheblichen Einschränkung der Funktion eines doppelt angelegten Organs? **Does the student have loss or seriously impaired function of any paired organ?**			
*Auge/***Eye**			
*Ohr/***Ear**			
*Lunge/***Lung**			
*Niere/***Kidney**			
*Hoden/Eierstock/***testicle/ovary**			
*Trägt die Schülerin/der Schüler:/***Does the student wear:**			
*eine Brille?/***glasses?**			
*Kontaktlinsen?/***contact lenses?**			
*eine Zahnspange?/***dental braces?**			
*Sonstiges:/***other:**			

Die falsche Darstellung jedweden Teils dieses Formulars stellt eine Verletzung der Regeln der Deutschen Schule Washington dar und führt zu einem Ausschluss der Schülerin/des Schülers von allen Wettkämpften und zu einer Annullierung aller Wettkämpfe an denen sie/er aufgrund eines gefälschten ärztlichen Attests teilgenommen hat. **Misrepresentation on any part of this form is a violation of the German School Washington policy and will result in the student being declared ineligible for the season and forfeiture of any contest(s) she/he competed in while having a forged medical examination.**

_____ _____ _____ _____

Unterschrift, Eltern oder Erziehungsberechtigte/r **Signature, Parent or Guardian** | *Datum/***Date** | *Unterschrift des Sportlers* **Signature, Sports Candidate** | *Datum/***Date**

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP_____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4										_____	_____	_____	_____
5										_____	_____	_____	_____
										_____			

To the best of my knowledge, the vaccines listed above were administered as indicated.

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

Clinic / Office Name
Office Address/ Phone Number

LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: _____ Date: _____
Parent or Guardian

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

The above child has a valid medical contraindication to being immunized at this time.

This is a ☐ permanent condition ☐ temporary condition until _____/_____/_____

Check appropriate box, indicate vaccine(s) and reasons: _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, per each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; and (h) Varicella."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at www.EDCP.org (Immunization).

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.EDCP.org (Immunization).

Vaccine Requirements For Children
Enrolled in Preschool Programs and in Schools — Per DHMH COMAR **10.06.04.03**
Maryland School Year 2014 - 2015 (Valid 9/1/14 - 8/31/15)

Required cumulative number of doses for each vaccine for PRESCHOOL aged children enrolled in educational programs							
Vaccine / Current Age of Child	**DTaP/DTP/DT[1]**	**Polio[2]**	**Hib[3]**	**Measles,[2,4] Mumps, Rubella**	**Varicella[2,4,5] (Chickenpox)**	**Hepatitis B**	**PCV[3] (Prevnar™)**
Less than 2 months	0	0	0	0	0	1	0
2 - 3 months	1	1	1	0	0	1	1
4 - 5 months	2	2	2	0	0	2	2
6 - 11 months	3	3	2	0	0	3	2
12 - 14 months	3	3	At least 1 dose given after 12 months of age	1	1	3	2
15 - 23 months	4	3	At least 1 dose given after 12 months of age	1	1	3	2
24—59 months	4	3	At least 1 dose given after 12 months of age	1	1	3	1
60 - 71 months	4	3	0	2	1	3	0

Required cumulative number of doses for each vaccine for children enrolled in KINDERGARTEN - 12th grade								
Grade Level Grade	**(Ungraded)**	**DTaP/DTP/Tdap/DT/Td[1,6]**	**Tdap[6]**	**Polio[2]**	**Measles,[2,4] Mumps, Rubella**	**Varicella[2,4,5] (Chickenpox)**	**Hepatitis B**	**Meningococcal**
Kindergarten	(5 yrs)	4		3	2	2 (NEW)	3	
Grades 1 - 6	(6 - 11 yrs)	4 or 3		3	2	1 or 2	3	
Grade 7	(11-12 yrs)	3	1 (NEW)	3	2	1 or 2	3	1 (NEW)
Grades 8-12	(12-18+ yrs)	3		3	2	1 or 2	3	

*** See footnotes on back for NEW Requirements for 2014-15 school year.**

Vaccine Requirements For Children
Enrolled in Preschool Programs and in Schools
Maryland School Year 2014 - 2015 (Valid 9/1/14 - 8/31/15)

FOOTNOTES

NEW Requirements for the 2014-15 school year are:

- **2 doses of Varicella vaccine for entry into Kindergarten**
- **1 dose of Tdap vaccine for entry into 7th grade**
- **1 dose of Meningococcal vaccine for entry into 7th grade**

1. If DT vaccine is given in place of DTP or DTaP, a physician documented medical contraindication is required.
2. Proof of immunity by positive blood test is acceptable in lieu of vaccine history for hepatitis B, polio and measles, mumps, rubella and varicella.
3. Hib and PCV(Prevnar^{TM}) are not required for children older than 59 months (5 years) of age.
4. All doses of measles, mumps, rubella and varicella vaccines should be given on or after the first birthday. However, upon record review for students in preschool through 12th grade, a preschool or school may count as valid vaccine doses administered less than or equal to four (4) days before first birthday.
5. One dose of varicella (chickenpox) is required for a student younger than 13 years old. Two doses of varicella vaccine are required for students entering Kindergarten and for previously unvaccinated students 13 years of age or older. Medical diagnosis of varicella disease is acceptable in lieu of vaccination. Medical diagnosis is documented history of disease provided by a physician or health care provider. Documentation must include month and year. In the absence of documentation a medical provider or local health department may verify immunity via blood test, **but revaccination may be more expedient.**
6. Four (4) doses of DTP/DTaP are required for children less than 7 years old. Three (3) doses of tetanus and diphtheria containing vaccine (any combination of the following — DTP, DTaP, Tdap, DT or Td) are required for children 7 years of age and older. One dose of Tdap vaccine received prior to entering 7th grade is acceptable and should be counted as a dose that fulfills the 7th grade Tdap requirement.