6451 Center Street
Mentor, OH 44060

# OHIO COMPULSORY IMMUNIZATION LAW

Student's Name ______________________ Date of Birth ____________

Name of Parent(s) ______________________

Address ______________________ Telephone ____________

Physician's Name ______________________ Telephone ____________

The OHIO STATE IMMUNIZATION LAW requires that each child entering school must have received or be in the process of receiving immunization against:

1. **Diphtheria, Pertussis, Tetanus, DTaP, DT (4 doses or <u>5 doses required if 4th dose given before 4th birthday</u>)**
2. **Poliomyelitis (a minimum of 3 doses.) *<u>The final dose must be given after the 4th birthday regardless of the number of previous doses.</u>* (4 doses required if a combination of OPV and IPV have been given and for children who entered Kindergarten after 2010)**
3. **MMR (1st vaccine required after 1st birthday, 2nd vaccine required at least 28 days after the 1st vaccine)**
4. **Hepatitis B Vaccine series (3 or 4 doses) *<u>The last dose must be administered after 24 weeks of age.</u>***
5. **Varicella/Chicken Pox (2 doses required prior to entering kindergarten beginning 2010.) 1st vaccine required *after* 1st birthday,2nd must be given at least 28 days after the 1st dose.) *<u>If MMR and Varicella are not given at the same time, the doses must be separated by at least 28 days.</u>***
6. **Tdap (Tetanus, Diphtheria, and Pertussis) is a booster requirement for students entering the 7th grade beginning 2010. *(Td booster was acceptable for all students who entered 7th grade in 2010 and 2011, only.)***

*A physical examination must be obtained within one year prior to the start of school and yearly for preschoolers.

**YOUR CHILD WILL NOT BE ELIGIBLE TO ATTEND SCHOOL IF THESE REQUIREMENTS ARE NOT MET**

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## STUDENT IMMUNIZATION RECORD

Diptheria, Whooping Cough, Tetanus (DTaP, DTP, DT)

| | Month | Day | Year |
|---|---|---|---|
| 1st Vaccine | ____ | ____ | ____ |
| 2nd Vaccine | ____ | ____ | ____ |
| 3rd Vaccine | ____ | ____ | ____ |
| 4th Vaccine | ____ | ____ | ____ |
| 5th Vaccine | ____ | ____ | ____ |
| 6th Vaccine (Tdap) | ____ | ____ | ____ |

Poliomyelitis (OPV,IPV)

| | Month | Day | Year |
|---|---|---|---|
| 1st Vaccine | ____ | ____ | ____ |
| 2nd Vaccine | ____ | ____ | ____ |
| 3rd Vaccine | ____ | ____ | ____ |
| 4th Vaccine | ____ | ____ | ____ |

Hepatitis B Vaccine Series

1st Vaccine ____/____/____
2nd Vaccine ____/____/____
3rd Vaccine ____/____/____
4th Vaccine ____/____/____

HIB Vaccine

1st Vaccine ____/____/____
2nd Vaccine ____/____/____
3rd Vaccine ____/____/____
4th Vaccine ____/____/____

Measles, Mumps, Rubella (MMR)

1st Vaccine ____/____/____
2nd Vaccine ____/____/____

TB Test (Optional)

Results: Negative ______
Positive ______
Type: ____________

Varicella (Chicken Pox) Vaccine

1st Vaccine ____/____/____
2nd Vaccine ____/____/____

Chicken Pox Disease ____/____/____

**Requirements may be waived for medical or religious reasons upon receipt of a signed statement from physician or parent/guardian respectively. When possible, please attach a copy of physician vaccine record. See your child's School Nurse with any questions.**

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Parent or Physician's Signature and Date