

STATE IMMUNIZATION LAW

Required

Students entering 7th grade must have:

1. Tdap (tetanus, diphtheria, and pertussis) vaccine
2. Meningococcal vaccination (New law as of Jan 2017)

Your child needs the following: Tdap___ Meningococcal___

These immunizations need to be completed before your child starts

7th grade in August 2017

In an effort to comply with these laws, and keep our students healthy Hamilton Co Public Health will be offering these vaccines **FREE** to all current 6th graders who are eligible.

If you child has health insurance and the health insurance covers vaccines, your child is not eligible for this. You must then make an appointment at your doctor's office to get this done.

.Date of clinic will be determined once permission slips are returned.

Permission slip on back



We ask all parents/guardians to fill out the permission slip on the reverse side and Return it to the school nurse office by _____

If you have questions please call Public Health, 832-9565

These immunizations need to be completed before your child starts 7th grade in August 2017.

Vaccine Administration Record for Tdap and Meningococcal

Child's Last Name _____ First Name _____

Birth Date _____ Current Age _____ Gender: (circle) Male/Female

Address _____ City _____ Phone _____

Please Mark One: _____ Insured (But insurance doesn't cover vaccines)
_____ Not Insured
_____ Medicaid (T19)
_____ Insured (insurance does cover vaccine cost) --Means child is not eligible.

Please answer the following questions?

1. Does the child have any food or medication allergies? Yes _____ No _____
If Yes, what are they? _____
2. Has the child had a serious reaction to a vaccine in the past? Yes _____ No _____
If Yes, what vaccine and what occurred? _____
3. Does the child have cancer or is the child on medications that lower the body's resistance to infection? Yes _____ No _____

I have read and understand the appropriate Vaccine Information Statement. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine and ask that the vaccine be given to the person's name for which I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination.



Signature of Parent/Guardian _____ Date _____

-----office use only-----

Tdap-Vaccine _____ Date _____ Lot # _____

Meningococcal Vaccine _____ Date _____ Lot # _____