



Wachusett Regional School District

Holden, Paxton, Princeton, Rutland, Sterling

FOR IMMEDIATE RELEASE

Wachusett Regional School District Kindergarten Registration For the 2010-2011 School Year

January 2010

Dear Parents/Guardians:

Kindergarten registration for the 2010-2011 school year has begun in the Wachusett Regional School District. Parents of children who will reach their fifth birthday **on or before August 31, 2010**, should contact the appropriate school **as soon as possible to arrange for a registration appointment**. There are no exceptions to the District's age policy.

Kindergarten registration materials are now available at the District website (www.wrsd.net). Parents who cannot access Kindergarten registration forms by visiting the District website may call the school where their child will enroll to request a packet of materials. Parents are **strongly encouraged** to complete the **entire** registration packet **prior to their appointment**. Please remember to bring completed forms to your appointment.

At the time of registration, parents are **required** to bring their child's **notarized birth certificate, an updated list of immunizations and proof of vision, hearing and lead screenings**. Please request these screenings at your child's **pre-enrollment physical**. The enclosed *Massachusetts School Health Record-Health Care Provider's Examination* form includes an area for physicians to record the results of vision, hearing and lead screening tests. Parents who have questions should call the main office of the appropriate school or the District's Central Office.

Please contact the school nurse if your child has specific medical conditions or concerns that may require a parent conference.

For your convenience, a listing of the schools in the Wachusett Regional School District, along with their phone numbers, is provided:

HOLDEN

Davis Hill School
508-829-1754

Dawson School
508-829-6828

Mayo School
508-829-3203

PAXTON

Paxton Center School
508-798-8576

PRINCETON

Thomas Prince School
978-464-2110

RUTLAND

Naquag Elementary School
508-886-2901

STERLING

Houghton Elementary School
978-422-2333

WRSD DISTRICT OFFICE

Jefferson School
508-829-1670 X 237

Jefferson School

1745 Main Street, Jefferson, MA 01522
Telephone: (508) 829-1670 Facsimile: (508) 829-1680
www.wrsd.net



Wachusett Regional School District

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Please bring the following completed documents with you when you bring your child to register for kindergarten:

- A completed Kindergarten Registration Form;
- A completed Home Language Survey;
- A completed Assignment to Kindergarten Sessions/Transportation Information Form;
- Completed Kindergarten Developmental History Form;
- A completed Massachusetts School Health Record Form (to be completed by student's physician), which includes:
 - Health Care Provider's Examination Form
 - Certificate of Immunization Form
- A copy of the student's Birth Certificate

At the time of registration, the Emergency Information Form will be completed.

January 31, 2008

Jefferson School

1745 Main Street, Jefferson, MA 01522
Telephone: (508) 829-1670 Facsimile: (508) 829-1680
www.wrsd.net

WACHUSETT REGIONAL SCHOOL DISTRICT
KINDERGARTEN REGISTRATION FORM
2010-2011 ACADEMIC YEAR

The information requested below mirrors information managed by the District's Student Information System, and is used to generate state and federal demographic and statistical reports.

Student Information

Student Name: _____ Preferred Name: _____
(Last, First, Middle)

Street Address: _____

Mailing Address: _____

Age: _____ Date of Birth: _____

Birthplace: _____ Gender: _____

Ethnicity: _____ Home Language: _____

Parent Name: _____ Parent Name: _____

Parent Home Phone: _____ Parent Home Phone: _____

Parent Cell Phone: _____ Parent Cell Phone: _____

Parent Employer: _____ Parent Employer: _____

Parent Work Phone: _____ Parent Work Phone: _____

Parent Email: _____ Parent Email: _____

Student Resides With: _____

Emergency Information

Emergency Contact 1: _____ Relationship: _____

Emergency Contact 1 Phone: _____ At: Work Home Cell

Emergency Contact 2: _____ Relationship: _____

Emergency Contact 2 Phone: _____ At: Work Home Cell

Emergency Contact 3: _____ Relationship: _____

Emergency Contact 3 Phone: _____ At: Work Home Cell

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Conditions: _____

WACHUSETT REGIONAL SCHOOL DISTRICT
KINDERGARTEN REGISTRATION FORM
2010-2011 ACADEMIC YEAR

ConnectEd Information (ConnectEd is an automated telephone notification system used by schools to contact parents in the event of inclement weather cancellations or delays, as well as important events happening in the school or District.)

ConnectEd Preferred Phone Number: _____

Demographic Information

Student's Ethnicity (select one):

- Hispanic or Latino (Cuban, Mexican, Chicano, Puerto Rican, Southern or Central American, or other Spanish culture or origin, regardless of race)
- Not Hispanic or Latino

Student's Race (select one or more races):

- White (having origins in any of the peoples of Europe, the Middle East or North Africa)
- Black or African American (having origins in any of the black racial groups of Africa)
- Native Hawaiian or Other Pacific Islander (having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands)
- American Indian or Alaska Native (having origins in any of the original peoples of North or South America including Central America and who maintains tribal affiliation or community attachment)
- Asian (having origins in any of the peoples of the Far East, Southeast Asia or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam)

If the student was born outside the US:

Is the child's first language English? Yes No

If "No," what was the child's first language? _____ Language used by parent with child? _____

Are other languages spoken in the home? If so, please list: _____

Education History:

Name and Address of Previous School (if applicable):

Additional Information:

Is the student a foster child under the Massachusetts Division of Social Services? Yes No

Is the student a "Ward of the Court?" Yes No

**WACHUSETT REGIONAL SCHOOL DISTRICT
HOME LANGUAGE SURVEY**

Message to Parents

Massachusetts Department of Elementary and Secondary Education regulations require that all schools determine the language(s) spoken in each student's home. This information is essential in order to provide meaningful instruction to all students.

Please complete **all** sections of this form and return it to school promptly. It will be placed in the child's cumulative folder. Thank you for your cooperation.

Student Information

NAME: _____ DATE: _____

SCHOOL: _____ DATE of BIRTH _____ GRADE: _____

I. Student's Place of Birth: _____
If not in US, date of first entry to a US school: _____

II. Other than English, are other languages spoken by student or in the home: YES NO
If "YES", what are they? _____

1. What language did the student first learn to speak? _____
2. What language does the parent/guardian most often use when speaking to the student? _____
3. What language does the student most often use when speaking to her/his parent/guardian in the home? _____
4. What language does the student most often use when speaking to other family members? _____
5. What language does the student most often use when speaking to friends? _____
6. In what language (s), if any, has the child learned to read and write? _____
7. If already attending a US school, has the child received ESL (English as a Second Language) services in the past?

8. In what language would the parent/guardian like to receive notices from school?

Circle choice ENGLISH NATIVE LANGUAGE (please specify) _____

I understand that my child will be given an initial assessment to determine English Language Proficiency and eligibility for ELL services. The assessment will take place at the child's school during school hours.

Parent Signature _____

Date _____

After an initial assessment, the District will determine if further testing is needed. If you want additional language proficiency testing done, regardless of the outcome of the initial assessment, please indicate this below:

I request an additional language assessment be completed for my daughter/son.

Parent Initials _____

Date _____

Cc: Curriculum Specialist-ELL
Supervisor of Pupil Personnel Services
Student File

Revised 1/10



Wachusett Regional School District

Holden, Paxton, Princeton, Rutland, Sterling

Assignment to Kindergarten Sessions/Transportation Information

Children are assigned to sessions according to the neighborhood in which they reside.

For transportation purposes, please indicate where your child will be picked up or dropped off, if other than at home.

Child's Name _____

Babysitter/Childcare Name _____

Address _____

Telephone Number _____

Thank you for taking the time to supply us with this information. If there is any other information you feel the school should know, please note it at the bottom of this sheet.

January 31, 2008

Wachusett Regional School District

KINDERGARTEN DEVELOPMENTAL HISTORY

Student's Name _____ Male Female

Home Address _____ Telephone No. _____

Birth Place _____ Birth Date _____

Do you feel that your child was delayed in any of the following:

Sitting Yes No Toileting Yes No
Crawling Yes No Feeding self Yes No
Walking Yes No Premature birth Yes No
Using simple words Yes No Normal delivery Yes No
Using full sentences Yes No Comments: _____

Has your child attended nursery school? Yes No
Where? _____ For how long? _____

The following questions refer to problems in such areas as hearing, vision, speech, language, and physical, intellectual, social and emotional development.

Do you have any reason to suspect your child might be in need of any special services or considerations in his/her school setting or curriculum? Yes No If Yes, please explain: _____

Has your child ever been evaluated for any condition or problem which might have a bearing on school performance? Yes No If Yes, please explain: _____

Were the recommendations carried out? Yes No Please explain: _____

Would information regarding this evaluation and/or treatment be available for the appropriate school personnel? Yes No
If Yes, please give name(s) and address(es) of person(s) or agency(ies) from whom this information may be obtained: _____

Is your child presently enrolled in any special school program? Yes No
If Yes, please explain: _____

What words best describes your child?
 shy self-confident cooperative
 happy jealous affectionate
 excitable nervous negative
 talkative other _____

Which hand does your child prefer? right left

What words best describe your child's feelings about coming to school?
 enthusiastic eager fearful happy
 indifferent apprehensive other _____

Is your child's speech easily understood by strangers? _____

Does he/she have a speech difficulty? _____

Does your child have any fears, such as:

- | | |
|--|--|
| <input type="checkbox"/> thunderstorms | <input type="checkbox"/> being alone |
| <input type="checkbox"/> the dark | <input type="checkbox"/> dogs or other animals |
| <input type="checkbox"/> noises | <input type="checkbox"/> other _____ |

Does your child have any special problems?

- | | | |
|---|---|--|
| <input type="checkbox"/> vision | <input type="checkbox"/> hearing | <input type="checkbox"/> eating |
| <input type="checkbox"/> nail-biting | <input type="checkbox"/> finger-sucking | <input type="checkbox"/> bed-wetting |
| <input type="checkbox"/> speech | <input type="checkbox"/> stubbornness | <input type="checkbox"/> temper-tantrums |
| <input type="checkbox"/> "accidents" in pants | <input type="checkbox"/> environmental allergies (pollen, etc.) | |
| <input type="checkbox"/> other _____ | If so, please list _____ | |

Does your child have any physical condition that would prevent him/her from participating in an active kindergarten program?

Yes No If Yes, please explain: _____

Does your child play with:

- | | | |
|---|--|---|
| <input type="checkbox"/> brother/sister | <input type="checkbox"/> alone | <input type="checkbox"/> younger children |
| <input type="checkbox"/> older children | <input type="checkbox"/> neighborhood children | <input type="checkbox"/> one close friend |

Has your child had any of the following experiences?

- | | | |
|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> library | <input type="checkbox"/> public park | <input type="checkbox"/> beach |
| <input type="checkbox"/> airplane trip | <input type="checkbox"/> bus trip | <input type="checkbox"/> bank |
| <input type="checkbox"/> camping | <input type="checkbox"/> train trip | <input type="checkbox"/> other _____ |

Can your child:

- | | |
|---|---|
| <input type="checkbox"/> zip | <input type="checkbox"/> button |
| <input type="checkbox"/> snap | <input type="checkbox"/> stay willingly with a relative |
| <input type="checkbox"/> tie shoes | <input type="checkbox"/> stay willingly with others |
| <input type="checkbox"/> take care of toilet needs | |
| <input type="checkbox"/> stay willingly with a babysitter | |

Does your child use at home:

- | | | |
|-----------------------------------|----------------------------------|--|
| <input type="checkbox"/> scissors | <input type="checkbox"/> crayons | <input type="checkbox"/> paste or glue |
| <input type="checkbox"/> puzzles | <input type="checkbox"/> pencils | <input type="checkbox"/> paint |
| <input type="checkbox"/> clay | <input type="checkbox"/> blocks | <input type="checkbox"/> books |

Previous School experiences:

- | | | |
|---|---|-------------------------------|
| <input type="checkbox"/> Head Start | <input type="checkbox"/> religious school | <input type="checkbox"/> None |
| <input type="checkbox"/> nursery school-where & for how long? _____ | | |

Please describe briefly your child's nursery/preschool experience: _____

May we have permission to contact your child's preschool? _____

Is your child able to:

- | | | |
|--|--|--|
| <input type="checkbox"/> identify colors | <input type="checkbox"/> print his/her name | <input type="checkbox"/> count to 10 |
| <input type="checkbox"/> count higher than 10 | <input type="checkbox"/> identify numbers 1-10 | <input type="checkbox"/> count objects to 10 |
| <input type="checkbox"/> identify numbers 10-20 | <input type="checkbox"/> identify alphabet letters | <input type="checkbox"/> count objects to 20 |
| <input type="checkbox"/> listen to and follow directions | <input type="checkbox"/> identify shapes | <input type="checkbox"/> pick up after him/herself |
| <input type="checkbox"/> complete tasks begun | <input type="checkbox"/> tell his/her full name | <input type="checkbox"/> tell his/her phone number |
| <input type="checkbox"/> occupy self with quiet play | <input type="checkbox"/> tell left from right | <input type="checkbox"/> sit and listen to a story |
| <input type="checkbox"/> tell his/her address | | |

Children are assigned to sessions according to the neighborhood in which they reside.

Thank you for taking the time to supply us with this information. Your cooperation is much appreciated. If there is any other information you feel the school should know, please note it at the bottom of this sheet.

Information supplied by

Signature

Date

Relationship to Child

DO NOT WRITE BELOW THIS LINE

GRADE _____ **BIRTH CERTIFICATE VERIFIED** _____ **NURSE INITIALS** _____
DATE _____

Wachusett Regional School District

HEALTH HISTORY

Student's Name _____

Class _____

Dear Parent/Guardian:

In order to provide better health services to your child, we ask that you complete the following health history. Please give dates if possible.

Date of last physical examination: _____

Physician's Name: _____

Date of last dental examination: _____

Dentist's Name: _____

Hearing/Vision Problems: _____

Hospitalizations: _____

Allergic reactions: _____

Operations: _____

Asthma Attacks: _____

Other respiratory: _____

Bone/Joint disease/injury: _____

Please give dates of Immunizations:

Other: _____

DPT: 1____ 2____ 3____ 4____ 5____

Communicable Diseases: _____

Oral Polio: 1____ 2____ 3____ 4____ 5____

Convulsions/seizures: _____

Hep B: 1____ 2____ 3____

Diabetes: _____

MMR: 1____ 2____

Dental Problems: _____

Hib: 1____ 2____ 3____ 4____

Ear Infections: _____

TB test: 1____ 2____

Throat Infections: _____

Lead Paint Test: 1____ 2____

Frequent headaches? _____

Results of examination by physician for:

Kidney problems: _____

Hearing: _____ Date: _____

Heart Problems/Murmur: _____

Vision: _____ Date: _____

Currently under treatment: _____

Does your child take medication for any reason? _____

NOTE: No medication can be given at school without written orders from your MD

Does your child have physical limitations that may require program modifications or restrictions? _____

Please add any other comments you would like to bring to the attention of the school nurse or physician:

Parent/Guardian signature: _____ Date: _____

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name _____ Male Female Date of Birth: _____
 Medical History _____

Pertinent Family History _____

Current Health Issues

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies: Please list: Medications _____ Food _____ Other _____ History of Anaphylaxis to _____ Epi-Pen®: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Asthma: Asthma Action Plan <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>Please attach</i>)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder: _____
<input type="checkbox"/>	<input type="checkbox"/>	Other (<i>Please specify</i>) _____

Current Medications (if relevant to the student's health and safety) Please circle those administered in school; a separate medication order form is needed for each medication administered in school.

Physical Examination Date of Examination: _____

Hgt: _____ (____%) Wgt: _____ (____%) BMI: _____ (____%) BP: _____

(Check = Normal / If abnormal, please describe.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

Screening:	(Pass) (Fail)	(Pass) (Fail)	(Pass) (Fail)
Vision: Right Eye	<input type="checkbox"/> <input type="checkbox"/>	Hearing: Right Ear	<input type="checkbox"/> <input type="checkbox"/>
Left Eye	<input type="checkbox"/> <input type="checkbox"/>	Left Ear	<input type="checkbox"/> <input type="checkbox"/>
Stereopsis	<input type="checkbox"/> <input type="checkbox"/>	Postural Screening:	<input type="checkbox"/> <input type="checkbox"/>
		(Scoliosis/Kyphosis/Lordosis)	

Laboratory Results: Lead _____ Date _____ Other _____

The entire examination was normal:

Targeted TB Skin Testing: Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors): Date of PPD: ____; Results: ____mm.

Referred for evaluation to: _____ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Fine/Gross Motor Deficit
<input type="checkbox"/> Emotional/Social	<input type="checkbox"/> Behavior	<input type="checkbox"/> Other	

Comments/Recommendations: _____

Y N This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions: _____

Y N Immunizations are complete; If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.

Signature of Examiner Circle: MD, DO, NP, PA Date _____

Please print name of Examiner.

Group Practice Telephone _____

Address City State
 Zip Code

Massachusetts Department of Public Health
CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / /

Sex: Female male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP- HepB-IPV)	1		Haemophilus influenzae type b (e.g., Hib, HepB- Hib, DTaP-Hib)	1	
	2			2	
	3			3	
		4			
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		Measles, Mumps, Rubella (MMR)	1	
	2			2	
	3		Varicella (Var)	1	
	4			2	
	5		Hepatitis A (HepA)	1	
	6			2	
	7				
Polio (e.g., IPV, DTaP-HepB-IPV)	1		Pneumococcal Polysaccharide (PPV23)	1	
	2			2	
	3		Influenza Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1		Other:	3	
	2				
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox.
Reliable history may be based on: <ul style="list-style-type: none"> • physician interpretation of parent/guardian description of chickenpox • physical diagnosis of chickenpox, or • serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.
 Doctor or nurse's name (please print) _____ Date: _____ / _____ / _____

Signature: _____

Facility name: _____

Summary of Recommendations for Childhood and Adolescent Immunization

Vaccine name and route	Schedule for routine vaccination and other guidelines (any vaccine can be given with another)	Schedule for catch-up vaccination and related issues	Contraindications and precautions (mild illness is not a contraindication)
Hepatitis B (HepB) <i>Give IM</i>	<ul style="list-style-type: none"> Vaccinate all children age 0 through 18yrs. Vaccinate all newborns with monovalent vaccine prior to hospital discharge. Give dose #2 at age 1–2m and the final dose at age 6–18m (the last dose in the infant series should not be given earlier than age 24wks). After the birth dose, the series may be completed using 2 doses of single-antigen vaccine or up to 3 doses of Comvax (ages 2m, 4m, 12–15m) or Pediarix (ages 2m, 4m, 6m), which may result in giving a total of 4 doses of hepatitis B vaccine. If mother is HBsAg-positive: give the newborn HBIG + dose #1 within 12hrs of birth; complete series at age 6m or, if using Comvax, at age 12–15m. If mother's HBsAg status is unknown: give the newborn dose #1 within 12hrs of birth. If mother is subsequently found to be HBsAg positive, give infant HBIG within 7d of birth and follow the schedule for infants born to HBsAg-positive mothers. 	<ul style="list-style-type: none"> Do not restart series, no matter how long since previous dose. 3-dose series can be started at any age. Minimum intervals between doses: 4wks between #1 and #2, 8wks between #2 and #3, and at least 16wks between #1 and #3 (e.g., 0-, 2-, 4m; 0-, 1-, 4m). 	<p>Contraindication</p> <ul style="list-style-type: none"> Previous anaphylaxis to this vaccine or to any of its components. <p>Precaution</p> <ul style="list-style-type: none"> Moderate or severe acute illness.
<p>Special Notes on Hepatitis B Vaccine (HepB) Dosing of HepB: Monovalent vaccine brands are interchangeable. For persons age 0 through 19yrs, give 0.5 mL of either Engerix-B or Recombivax HB. Alternative dosing schedule for unvaccinated adolescents age 11 through 15yrs: Give 2 doses Recombivax HB 1.0 mL (adult formulation) spaced 4–6m apart. (Engerix-B is not licensed for a 2-dose schedule.) For preterm infants: Consult ACIP hepatitis B recommendations (<i>MMWR</i> 2005; 54 [RR-16]).*</p>			
DTaP, DT (Diphtheria, tetanus, acellular pertussis) <i>Give IM</i>	<ul style="list-style-type: none"> Give to children at ages 2m, 4m, 6m, 15–18m, 4–6yrs. May give dose #1 as early as age 6wks. May give #4 as early as age 12m if 6m have elapsed since #3 and the child is unlikely to return at age 15–18m. Do not give DTaP/DT to children age 7yrs and older. If possible, use the same DTaP product for all doses. 	<ul style="list-style-type: none"> #2 and #3 may be given 4wks after previous dose. #4 may be given 6m after #3. If #4 is given before 4th birthday, wait at least 6m for #5 (age 4–6yrs). If #4 is given after 4th birthday, #5 is not needed. 	<p>Contraindications</p> <ul style="list-style-type: none"> Previous anaphylaxis to this vaccine or to any of its components. For DTaP/Tdap only: encephalopathy within 7d after DTP/DTaP. <p>Precautions</p> <ul style="list-style-type: none"> Moderate or severe acute illness. History of Arthus reaction following a prior dose of tetanus- and/or diphtheria-toxoid-containing vaccine, including MCV4. Guillain-Barré syndrome (GBS) within 6wks after previous dose of tetanus-toxoid-containing vaccine. For DTaP only: Any of these events following a previous dose of DTP/DTaP: 1) temperature of 105°F (40.5°C) or higher within 48hrs; 2) continuous crying for 3hrs or more within 48hrs; 3) collapse or shock-like state within 48hrs; 4) convulsion with or without fever within 3d. For DTaP/Tdap only: Unstable neurologic disorder. <p>Note: Tdap may be given to pregnant women at the provider's discretion.</p>
Td, Tdap (Tetanus, diphtheria, acellular pertussis) <i>Give IM</i>	<ul style="list-style-type: none"> Give 1-time Tdap dose to adolescents age 11–12yrs if 5yrs have elapsed since last dose DTaP; then boost every 10yrs with Td. Give 1-time dose of Tdap to all adolescents who have not received previous Tdap. Special efforts should be made to give Tdap to persons age 11yrs and older who are 1) in contact with infants younger than age 12m and 2) healthcare workers with direct patient contact. In pregnancy, when indicated, give Td or Tdap in 2nd or 3rd trimester. If not administered during pregnancy, give Tdap in immediate postpartum period. 	<ul style="list-style-type: none"> If never vaccinated with tetanus- and diphtheria-containing vaccine: give Td dose #1 now, dose #2 4wks later, and dose #3 6m after #2, then give booster every 10yrs. A 1-time Tdap may be substituted for any dose in the series, preferably as dose #1. For persons who previously received a Td booster, an interval of 2yrs or less between Td and Tdap may be used. 	
Polio (IPV) <i>Give SC or IM</i>	<ul style="list-style-type: none"> Give to children at ages 2m, 4m, 6–18m, 4–6yrs. May give dose #1 as early as age 6wks. Not routinely recommended for U.S. residents age 18yrs and older (except certain travelers). 	<ul style="list-style-type: none"> The final dose should be given on or after the 4th birthday and at least 6m from the previous dose. If dose #3 is given after 4th birthday, dose #4 is not needed if dose #3 is given at least 6m after dose #2. 	<p>Contraindication</p> <ul style="list-style-type: none"> Previous anaphylaxis to this vaccine or to any of its components. <p>Precautions</p> <ul style="list-style-type: none"> Moderate or severe acute illness. Pregnancy.
Human papilloma-virus (HPV) <i>Give IM</i>	<ul style="list-style-type: none"> Give 3-dose series to girls at age 11–12yrs on a 0, 2, 6m schedule. (May be given as early as age 9yrs.) Vaccinate all older girls and women (through age 26yrs) who were not previously vaccinated. 	<p>Minimum intervals between doses: 4wks between #1 and #2; 12 wks between #2 and #3. Overall, there must be at least 24wks between doses #1 and #3.</p>	<p>Contraindication</p> <ul style="list-style-type: none"> Previous anaphylaxis to this vaccine or to any of its components. <p>Precautions</p> <ul style="list-style-type: none"> Moderate or severe acute illness. Pregnancy.

*This document was adapted from the recommendations of the Advisory Committee on Immunization Practices (ACIP). To obtain copies of the recommendations, call the CDC-INFO Contact Center at (800) 232-4636; visit CDC's website at www.cdc.gov/vaccines/pubs/ACIP-list.htm; or visit the Immunization Action Coalition (IAC)

website at www.immunize.org/acip. This table is revised periodically. Visit IAC's website at www.immunize.org/childrules to make sure you have the most current version.

Summary of Recommendations for Childhood and Adolescent Immunization

Vaccine name and route	Schedule for routine vaccination and other guidelines (any vaccine can be given with another)	Schedule for catch-up vaccine administration and related issues	Contraindications and precautions (mild illness is not a contraindication)
Varicella (Var) (Chickenpox) <i>Give 5C</i>	<ul style="list-style-type: none"> • Give dose #1 at age 12–15m. • Give dose #2 at age 4–6yrs. Dose #2 may be given earlier if at least 3m since dose #1. • Give a 2nd dose to all older children and adolescents with history of only 1 dose. • MMRV may be used in children age 12m through 12yrs. 	<ul style="list-style-type: none"> • If younger than age 13yrs, space dose #1 and #2 at least 3m apart. If age 13yrs or older, space at least 4wks apart. • May use as postexposure prophylaxis if given within 5d. • If Var and either MMR, LAIV, and/or yellow fever vaccine are not given on the same day, space them at least 28d apart. 	<p>Contraindications</p> <ul style="list-style-type: none"> • Previous anaphylaxis to this vaccine or to any of its components. • Pregnancy or possibility of pregnancy within 4wks. • Children on high-dose immunosuppressive therapy or who are immunocompromised because of malignancy and primary or acquired cellular immunodeficiency, including HIV/AIDS (although vaccination may be considered if CD4+ T-lymphocyte percentages are either 15% or greater in children ages 1 through 8yrs or 200 cells/μL or greater in children age 9yrs and older). <p>Precautions</p> <ul style="list-style-type: none"> • Moderate or severe acute illness. • If blood, plasma, and/or immune globulin (IG or VZIG) were given in past 11m, see ACIP statement <i>General Recommendations on Immunization*</i> regarding time to wait before vaccinating. <p>Note: For patients with humoral immunodeficiency or leukemia, see ACIP recommendations*.</p>
MMR (Measles, mumps, rubella) <i>Give 5C</i>	<ul style="list-style-type: none"> • Give dose #1 at age 12–15m. • Give dose #2 at age 4–6yrs. Dose #2 may be given earlier if at least 4wks since dose #1. • Give a 2nd dose to all older children and teens with history of only 1 dose. • MMRV may be used in children age 12m through 12yrs. 	<ul style="list-style-type: none"> • If MMR and either Var, LAIV, and/or yellow fever vaccine are not given on the same day, space them at least 28d apart. • When using MMR for both doses, minimum interval is 4wks. • When using MMRV for both doses, minimum interval is 3m. • Within 72hrs of measles exposure, give 1 dose of MMR as postexposure prophylaxis to susceptible healthy children age 12m and older. 	<p>Contraindications</p> <ul style="list-style-type: none"> • Previous anaphylaxis to this vaccine or to any of its components. • Pregnancy or possibility of pregnancy within 4wks. • Severe immunodeficiency (e.g., hematologic and solid tumors; receiving chemotherapy; congenital immunodeficiency; long-term immunosuppressive therapy, or severely symptomatic HIV). Note: HIV infection is NOT a contraindication to MMR for children who are not severely immunocompromised (consult ACIP MMR recommendations [MMWR 1998;47 [RR-8] for details*). <p>Precautions</p> <ul style="list-style-type: none"> • Moderate or severe acute illness. • If blood, plasma, or immune globulin given in past 11m, see ACIP statement <i>General Recommendations on Immunization*</i> regarding time to wait before vaccinating. • History of thrombocytopenia or thrombocytopenic purpura. <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>Note: MMR is not contraindicated if a TST (tuberculosis skin test) was recently applied. If TST and MMR are not given on same day, delay TST for at least 4wks after MMR.</p> </div>
Seasonal Influenza Trivalent inactivated influenza vaccine (TIV) <i>Give 1M</i> Live attenuated influenza vaccine (LAIV) <i>Give intranasally</i>	<ul style="list-style-type: none"> • Vaccinate all children and teens age 6m through 18yrs. • Special efforts should be made to vaccinate the following children, teens, and persons age 19yrs and older because they are at higher risk for influenza complications: those ages 6 through 59m; on long-term aspirin therapy (through age 18yrs); with pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, cognitive, neurologic/neuromuscular, hematologic, or metabolic (including diabetes) disorders; with immunosuppression (including that caused by medications or HIV); residing in long-term care facilities; who will be pregnant during influenza season. • Vaccinate children, teens, and adults who are household contacts, out-of-home caregivers, or workplace contacts of the persons listed in bullet #2 above; or of children age 0–59m; or of adults age 50yrs and older. • LAIV may be given to healthy, non-pregnant persons age 2–49yrs. • Give 2 doses to first-time vaccinees age 6m through 8yrs, spaced 4wks apart. • For TIV, give 0.25 mL dose to children age 6–35m and 0.5 mL dose if age 3yrs and older. 	<ul style="list-style-type: none"> • Do not begin series in infants older than age 15wks 0 days. • Intervals between doses may be as short as 4wks. • If prior vaccination included use of different or unknown brand(s), a total of 3 doses should be given. 	<p>Contraindications</p> <ul style="list-style-type: none"> • Previous anaphylaxis to this vaccine, to any of its components, or to eggs. • For LAIV only: age younger than 2yrs; pregnancy; chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, neurologic/neuromuscular, hematologic, or metabolic (including diabetes) disorders; immunosuppression (including that caused by medications or HIV); for children and teens ages 6m through 18yrs, current long-term aspirin therapy; for children age 2 through 4yrs, wheezing or asthma within the past 12m, per healthcare provider statement. <p>Precautions</p> <ul style="list-style-type: none"> • Moderate or severe acute illness. • History of Guillain-Barré syndrome (GBS) within 6wks of a previous influenza vaccination. • For LAIV only: close contact with an immunosuppressed person when the person requires protective isolation. <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>Note: If LAIV and either MMR, Var, and/or yellow fever vaccine are not given on the same day, space them at least 28d apart.</p> </div>
Rotavirus (RV) <i>Give orally</i>	<ul style="list-style-type: none"> • Rotarix (RV1): give at age 2m, 4m. • RotaTeq (RV5): give at age 2m, 4m, 6m. • May give dose #1 as early as age 6wks. • Give final dose no later than age 8m 0 days. 	<ul style="list-style-type: none"> • Do not begin series in infants older than age 15wks 0 days. • Intervals between doses may be as short as 4wks. • If prior vaccination included use of different or unknown brand(s), a total of 3 doses should be given. 	<p>Contraindication</p> <ul style="list-style-type: none"> • Previous anaphylaxis to this vaccine or to any of its components. If allergy to latex, use RV5. <p>Precautions</p> <ul style="list-style-type: none"> • Moderate or severe acute illness. • Altered immunocompetence. • Moderate to severe acute gastroenteritis or chronic gastrointestinal disease. • History of intussusception.

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Hib <i>(Haemophilus influenzae type b)</i> Give IM	<ul style="list-style-type: none"> • ActHib (PRP-T): give at age 2m, 4m, 6m, 12–15m (booster dose). • PedvaxHIB or Comvax (containing PRP-OMP): give at age 2m, 4m, 12–15m (booster dose). • Dose #1 of Hib vaccine should not be given earlier than age 6wks. • The last dose (booster dose) is given no earlier than age 12m and a minimum of 8wks after the previous dose. • Hib vaccines are interchangeable; however, if different brands of Hib vaccines are administered for dose #1 and dose #2, a total of 3 doses are necessary to complete the primary series in infants. • Any Hib vaccine may be used for the booster dose. • Hib is not routinely given to children age 5yrs and older. • Hibertix is approved ONLY for the booster dose at age 15m through 4yrs. 	<p>All Hib vaccines:</p> <ul style="list-style-type: none"> • If #1 was given at 12–14m, give booster in 8wks. • Give only 1 dose to unvaccinated children ages 15 through 59m. <p>ActHib:</p> <ul style="list-style-type: none"> • #2 and #3 may be given 4wks after previous dose. • If #1 was given at age 7–11m, only 3 doses are needed; #2 is given 4–8wks after #1, then boost at age 12–15m (wait at least 8wks after dose #2). <p>PedvaxHIB and Comvax:</p> <ul style="list-style-type: none"> • #2 may be given 4wks after dose #1. 	<p>Contraindications</p> <ul style="list-style-type: none"> • Previous anaphylaxis to this vaccine or to any of its components. • Age younger than 6wks. <p>Precaution</p> <p>Moderate or severe acute illness.</p>
Pneumococcal conjugate (PCV) Give IM	<ul style="list-style-type: none"> • Give at ages 2m, 4m, 6m, 12–15m. • Dose #1 may be given as early as age 6wks. • Give 1 dose to unvaccinated healthy children age 24–59m. • High-risk** children ages 24–59m: Give 2 doses at least 8wks apart if they previously received fewer than 3 doses; give 1 dose if they previously received 3 doses. • PCV is not routinely given to children age 5yrs and older. <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>**High-risk: Those with sickle cell disease; anatomic/functional asplenia; chronic cardiac, pulmonary, or renal disease; diabetes; cerebrospinal fluid leaks; HIV infection; immunosuppression; diseases associated with immunosuppressive and/or radiation therapy; or who have or will have a cochlear implant.</p> </div>	<ul style="list-style-type: none"> • For age 7–11m: If history of 0–2 doses, give additional doses 4wks apart with no more than 3 total doses by age 12m; then give booster 8wks later. • For age 12–23m: If 0–1 dose before age 12m, give 2 doses at least 8wks apart. If 2–3 doses before age 12m, give 1 dose at least 8wks after previous dose. • For age 24–59m: If patient has had no previous doses, or has a history of 1–3 doses given before age 12m but no booster dose, or has a history of only 1 dose given at age 12–23m, give 1 dose now. 	<p>Contraindication</p> <p>Previous anaphylaxis to this vaccine or to any of its components.</p> <p>Precaution</p> <p>Moderate or severe acute illness.</p>
Pneumococcal polysaccharide (PPSV) Give IM or SC	<ul style="list-style-type: none"> • Give 1 dose at least 8wks after final dose of PCV to high-risk children age 2yrs and older. • For children who are immunocompromised or have sickle cell disease or functional or anatomic asplenia, give a 2nd dose of PPSV 5yrs after previous PPSV (consult ACIP PPSV recommendations at http://www.cdc.gov/vaccines/pubs/ACIP-list.htm). 		<p>Contraindication</p> <p>Previous anaphylaxis to this vaccine or to any of its components.</p> <p>Precaution</p> <p>Moderate or severe acute illness.</p>
Hepatitis A (HepA) Give IM	<ul style="list-style-type: none"> • Give 2 doses to all children at age 1yr (12–23m) spaced 6m apart. • Vaccinate all previously unvaccinated children and adolescents age 2yrs and older who <ul style="list-style-type: none"> - Wish to be protected from HAV infection. - Live in areas where vaccination programs target older children. - Travel anywhere except U.S., W. Europe, N. Zealand, Australia, Canada, or Japan. - Have chronic liver disease, clotting factor disorder, or are MSM adolescents. - Are users of illicit drugs (injectable or non-injectable). - Anticipate close personal contact with an international adoptee from a country of high or intermediate endemicity during the first 60 days following the adoptee's arrival in the U.S. 	<ul style="list-style-type: none"> • Minimum interval between doses is 6m. • Children who are not fully vaccinated by age 2yrs can be vaccinated at subsequent visits. • Consider routine vaccination of children age 2yrs and older in areas with no existing program. • Give 1 dose as postexposure prophylaxis to incompletely vaccinated children age 12m and older who have recently (during the past 2wks) been exposed to hepatitis A virus. 	<p>Contraindication</p> <p>Previous anaphylaxis to this vaccine or to any of its components.</p> <p>Precautions</p> <ul style="list-style-type: none"> • Moderate or severe acute illness. • Pregnancy.
Meningococcal conjugate (MCV4) Give IM — polysaccharide (MPSV4) Give SC	<ul style="list-style-type: none"> • Give 1-time dose of MCV4 to adolescents age 11 through 18yrs. • Vaccinate all college freshmen living in dorms who have not been vaccinated. • Vaccinate all children age 2yrs and older who have any of the following risk factors: <ul style="list-style-type: none"> - Anatomic or functional asplenia, or persistent complement component deficiency. - Travel to or reside in countries in which meningococcal disease is hyperendemic or epidemic (e.g., the "meningitis belt" of Sub-Saharan Africa). <p>Note: Use MPSV4 ONLY if there is a permanent contraindication or precaution to MCV4.</p>	<p>If previously vaccinated with MPSV4 or MCV4 and risk of meningococcal disease persists, revaccinate with MCV4 after 3 years (if first dose given at age 2 through 6 yrs) or after 5 yrs (if previous dose given at age 7 yrs or older). If the only risk factor is living in a campus dormitory, there is no need to give a 2nd dose.</p>	<p>Contraindication</p> <p>Previous anaphylaxis to this vaccine or to any of its components, including diphtheria toxoid (for MCV4).</p> <p>Precautions</p> <ul style="list-style-type: none"> • Moderate or severe acute illness. • For MCV4 only: history of Guillain-Barré syndrome (GBS).

