General Health Appraisal & Immunizations

Dear Parents,

Our school works hard to ensure compliance with health requirements and immunization laws. Your help providing updated immunization records at the beginning of school and when your child receives additional vaccine(s) is greatly appreciated. The immunizations must be received on a completed Certificate of Immunization certifying that the child has received the minimum immunizations.

Many parents are surprised to find their child is under immunized and consider their Health Care Provider was on top of it. Child Priority does accept children with medical, religious and personal exemptions to vaccines.

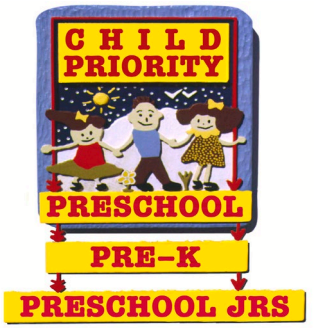
Immunizations are an important part of our children's health care and Colorado law *requires* that children going to school be vaccinated to prevent vaccine-preventable diseases. The purpose of this letter is to let you know which vaccines are required for school attendance and which vaccines are recommended for best protection against vaccine-preventable diseases.

As a parent, it is important to know that in addition to the vaccines *required by the State of Colorado Board for school entry, there are vaccines that are recommended by the Advisory Committee on Immunization Practice (ACIP). This is the immunization schedule that will best protect your child.*

A resource developed for parents with frequently asked questions about the safety and importance of vaccines can be located at www.ImmunizeForGood.com The Colorado Immunization Section's website is located at: www.ColoradoImmunizations.com

General Health Appraisal for Enrollment

Child's Name:_____ Birth Date:_____/_____/_____



Date of most recent health exam:_____/_____/_____ (Note: Must be within the last 12 months)

a) Attach Child's Certificate of Immunization Record to this signed health appraisal

Health History & Medical Information: Pertinent to routine child care and emergencies

_____ None _____ Described Below

Special Diets:_____

Allergies:_____

Types of Reaction:_____

Current Medication:_____

Weight:_____ Height:_____ Vision:_____ Hearing:_____

Describe any recurrent health problems:_____

Health Provider Name:_____ Date:_____/_____/_____ Address:_____

Health Provider Signature:_____ Title:_____ Doctor's Office Stamp:

COLORADO CERTIFICATE OF IMMUNIZATION

cdphe.colorado.gov/immunization

COLORADO
Department of Public Health & Environment

This form is to be completed by a health care provider (physician [MD, DO], advanced practice nurse [APN] or delegated physician's assistant [PA]) or school health authority. School-required immunizations follow the Advisory Committee on Immunization Practices (ACIP) schedule. If the student provides an immunization record in any other format apart from this Certificate or an Approved Alternate Certificate (details found at cdphe.colorado.gov/immunization/forms), the school health authority must transcribe the record onto this form. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at sixth grade entry.

Student Name: _____ **Date of birth:** _____

Parent/guardian:(if student is under 18 years of age and not emancipated) _____

Required Vaccines

	Immunization date(s) MM/DD/YY						**Titer Date*** MM/DD/YY
HepB Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)†							
Tdap Tetanus, Diphtheria, Pertussis†							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella ‡							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease		**Varicella** - positive screen date	

*The shaded area under "Titer Date" indicates that a titer is not acceptable proof of immunity for this vaccine.

In several instances, laboratory confirmation of positive titers are an acceptable alternative to written documentation of vaccination. A positive laboratory titer report must be provided to the school to document immunity. More information on titers can be found within the Colorado Board of Health rule 6 CCR 1009-2.
† For DTaP and Tdap, both the diphtheria and tetanus titers must be positive. A titer is never acceptable to demonstrate immunity to pertussis.
‡ Laboratory confirmation of positive titers are an acceptable alternative to the MMR vaccine only when titers for all three components (measles, mumps, and rubella) are positive.

Recommended Vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
RV Rotavirus							
MCV4 Meningococcal							
MenB Meningococcal							
HepA Hepatitis A							
Flu Influenza							
COVID-19							
Other							

Health care provider printed name/signature: _____ / _____ Date: _____

Student is current on required immunizations for age (circle one): OR Yes No
Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

Last Reviewed: May 2023

Emergency Card Information

(Must be filled-out annually)

Child's name_____ Birthdate___ /___ /___

Address_____ City_____ Zip_____

Parent name_____ Home #_____

Work #_____ Cell #_____

Work #_____ Cell #_____

Email address_____ *(Print Clearly)*

If neither parent/guardian can be reached in case of emergency, please list alternate contacts:

Name_____ Phone_____

Name_____Phone_____

Medical Information:

Pediatrician _____ Address_____ Phone_____

Dentist _____ Address_____ Phone_____

Hospital of choice_____ Address_____

My Child is allergic to_____

and I have filled out an Emergency Medical permission forms if medication is stored at school.

Any special medical, physical, dietary, or other needs of this child? If yes, describe:

_____

I, _____, hereby give permission to Child Priority School to ask a doctor for medical or surgical care for my child should an emergency arise. This includes calling 911 if necessary. It is understood that a conscientious effort will be made to immediately locate me or the other head of the household. We accept any medical expenses incurred.

_____ Date___ /___ /___

Signature of Parent or Guardian

Persons Authorized to pick-up your child other than parents:

Name_____Address_____Phone_____

Name_____Address_____Phone_____

Name_____Address_____Phone_____

Children will not be released to anyone other than parents, guardians, or those you have listed here, unless advance notice is given to the child's teacher. Please send a note or call the school.

Special information about my child

Is there anything you might tell us about your child that will help us better serve him/her? This might include health issues, toileting, fears or any behavior you think is of importance.

_____

_____

_____Date: _____ /_____ /_____

Signature of Parent or Guardian