Grasso Technical High School Athlete Eligibility Packet Sign-off

Student Name: ___________________________ Grade: _____ Sport: ________________

All students and parents must read and sign all attached documents and parents must sign this cover sheet in order for your son or daughter to be eligible to play sports at Grasso Tech.

I ___________________________ (Parent/Guardian Name) completed the following forms:

1. Student and Parent Concussion Consent Form (to: Mr. Antoch)
2. Sudden Cardiac Arrest Student and parent consent form (to: Mr. Antoch)
3. STV(Student Transportation Form (to: Mr. Antoch)
4. Parent Permission Form (to: Mr. Antoch)
5. Current Physical Form (to: Nurse Oatley)

Parent Signature: ___________________________ Date: _______________________

I ___________________________ (Parent/Guardian Name) also completed all the Online Concussion Training by going to the link below:

I ___________________________ (Student Name) completed all the Online Concussion Training by going to the link below:

Student/Parent CIAC approved Concussion Training Link:
http://www.concussioncentral.ciacsports.com/index.html

Student Signature: ___________________________ Date: _______________________

Parent Signature: ___________________________ Date: _______________________

Parent Signature: ___________________________ Date: _______________________

Parent Signature: ___________________________ Date: _______________________
This consent form was developed to provide students and parents with current and relevant information regarding concussions and to comply with Connecticut General Statutes (C.G.S.) Chapter 163, Section 149b: Conussions: Training courses for coaches. Education plan. Informed consent form. Development or approval by the State Board of Education and Section 10-149c: Student athletes and concussions. Removal from athletic activities. Notification of parent or legal guardian. Revocation of coaching permit.

What is a Concussion?
National Athletic Trainers Association (NATA) - A concussion is a “trauma induced alteration in mental status that may or may not involve loss of consciousness.”

Centers for Disease Control and Prevention (CDC) - “A concussion is a type of traumatic brain injury, or TBI, caused by a bump, blow, or jolt to the head that can change the way your brain normally works. Concussions can also occur from a blow to the body that causes the head to move rapidly back and forth.”-CDC, Heads Up: Concussion 
http://www.cdc.gov/headsup/basics/concussion_whatis.html

Even a “ding,” “getting your bell rung,” or what seems to be mild bump or blow to the head can be serious” -CDC, Heads Up: Concussion Fact Sheet for Coaches http://www.cdc.gov/concussion/HeadsUp/pdf/Fact_Sheet_Coaches-a.pdf

Section 1. Concussion Education Plan Summary
The Concussion Education Plan and Guidelines for Connecticut Schools was approved by the Connecticut State Board of Education in January 2015. Below is an outline of the requirements of the Plan. The complete document is accessible on the CSDE Web site: http://www.sde.ct.gov/sde/cwp/view.asp?a=2663&q=335572

State law requires that each local and regional board of education must approve and then implement a concussion education plan by using written materials, online training or videos, or in-person training that addresses, at a minimum the following:
1. The recognition of signs or symptoms of concussion.
2. The means of obtaining proper medical treatment for a person suspected of sustaining a concussion.
3. The nature and risks of concussions, including the danger of continuing to engage in athletic activity after sustaining a concussion.
4. The proper procedures for allowing a student athlete who has sustained a concussion to return to athletic activity.

Section 2. Signs and Symptoms of a Concussion: Overview
A concussion should be suspected if any one or more of the following signs or symptoms are present, or if the coach/evaluator is unsure, following an impact or suspected impact as described in the CDC definition above.

Signs of a concussion may include (i.e. what the athlete displays/looks like to an observer):
- Confusion/disorientation/irritability
- Trouble resting/getting comfortable
- Lack of concentration
- Slow response/drowsiness
- Incoherent/slurred speech
- Slow/clumsy movements
- Loses consciousness
- Amnesia/memory problems

Symptoms of a concussion may include (i.e. what the athlete reports):
- Acts silly/combative/aggressive
- Repeatedly ask same questions
- Dazed appearance
- Restless/irritable
- Constant attempts to return to play
- Constant motion
- Disproportionate/inappropriate reactions
- Balance problems
- Oversensitivity to sound/light/touch
- Ringing in ears
- Feeling foggy or groggy

State law requires that a coach MUST immediately remove a student-athlete from participating in any intramural or interscholastic athletic activity who: a) is observed to exhibit signs, symptoms or behaviors consistent with a concussion following a suspected blow to the head or body, or b) is diagnosed with a concussion, regardless of when such concussion or head injury may have occurred. Upon removal of the athlete, a qualified school employee must notify the parent or legal guardian within 24 hours that the student athlete has exhibited signs and symptoms of a concussion.

Section 3. Return to Play (RTP) Protocol Overview
Currently, it is impossible to accurately predict how long an individual’s concussion will last. There must be full recovery before a student-athlete is allowed to resume participating in athletic activity. Connecticut law now requires that no athlete may resume participation until they have received written medical clearance from a licensed health care professional (physician, physician assistant, advanced practice registered nurse (APRN), athletic trainer) trained in the evaluation and management of concussions.

**Concussion Management Requirements:**
1. No athlete SHALL return to participation in the athletic activity on the same day of concussion.
2. If there is any loss of consciousness, vomiting or seizures, the athlete MUST be immediately transported to the hospital.
3. Close observation of an athlete MUST continue following a concussion. The athlete should be monitored for an appropriate amount of time following the injury to ensure that there is no worsening/escalation of symptoms.
4. Any athlete with signs or symptoms related to a concussion MUST be evaluated by a licensed health care professional (physician, physician assistant, advanced practice registered nurse (APRN), athletic trainer) trained in the evaluation and management of concussions.
5. The athlete MUST obtain an initial written clearance from one of the licensed health care professionals identified above directing her/him into a well-defined RTP stepped protocol similar to the one outlined below. If at any time signs or symptoms return during the RTP progression, the athlete should cease activity*.
6. After the RTP protocol has been successfully administered (no longer exhibits any signs or symptoms or behaviors consistent with concussions), final written medical clearance is required by one of the licensed health care professionals identified above for the athlete to fully return to unrestricted participation in practices and competitions.

**Medical Clearance RTP protocol (Recommended one full day between steps)**

<table>
<thead>
<tr>
<th>Rehabilitation stage</th>
<th>Functional exercise at each stage of rehabilitation</th>
<th>Objective of each stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No activity</td>
<td>Complete physical and cognitive rest until asymptomatic. School may need to be modified.</td>
<td>Recovery</td>
</tr>
<tr>
<td>2. Light aerobic exercise</td>
<td>Walking, swimming or stationary cycling maintaining intensity &lt;70% of maximal exertion; no resistance training</td>
<td>Increase Heart Rate</td>
</tr>
<tr>
<td>3. Sport specific exercise</td>
<td>Skating drills in ice hockey, running drills in soccer; no head impact activities</td>
<td>Add Movement</td>
</tr>
<tr>
<td>4. Non-contact sport drills</td>
<td>Progression to more complex training drills, i.e. passing drills in football and ice hockey; may start progressive resistance training</td>
<td>Exercise, coordination and cognitive load</td>
</tr>
<tr>
<td>5. Full contact sport drills</td>
<td>Following final medical clearance, participate in normal training activities</td>
<td>Restore confidence and assess functional skills by coaching staff</td>
</tr>
<tr>
<td>6. Full activity</td>
<td>No restrictions</td>
<td>Return to full athletic participation</td>
</tr>
</tbody>
</table>

* If at any time signs or symptoms should worsen during the RTP progression the athlete should stop activity that day. If the athlete’s symptoms are gone the next day, she/he may resume the RTP progression at the last step completed in which no symptoms were present. If symptoms return and don’t resolve, the athlete should be referred back to her/his medical provider.

**Section 4. Local/Regional Board of Education Policies Regarding Concussions**

***** Attach local or regional board of education concussion policies *****

I have read and understand this document the “Student and Parent Concussion Informed Consent Form” and understand the severities associated with concussions and the need for immediate treatment of such injuries.

**Student name:** ____________________________ **Date** ______ **Signature** __________________________

(Print Name)

I authorize my child to participate in ________________ __________________ ______ for school year ________________

(Sport/Activity)

**Parent/Guardian name:** __________________________ **Date** ______ **Signature** __________________________

(Print Name)

**References:**
   - [http://www.nfhs.org](http://www.nfhs.org)

**Resources:**
NOTE: This document was developed to provide student-athletes and parents/guardians with current and relevant information regarding sudden cardiac arrest. A new form is required to be read, signed, dated and kept on file by the student-athlete’s associated school district annually to comply with Connecticut General Statutes Chapter 163, Section 10-149f: SUDDEN CARDIAC ARREST AWARENESS EDUCATION PROGRAM.

Part I – SUDDEN CARDIAC ARREST - What is sudden cardiac arrest?
Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA doesn’t just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A student’s SCA will likely result from an inherited condition, while an adult’s SCA may be caused by either inherited or lifestyle issues. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart’s electrical system, causing the heart to suddenly stop beating.

Part II - HOW COMMON IS SUDDEN CARDIAC ARREST IN THE UNITED STATES?
SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. It is a leading cause of death for student athletes.
According to an April 2014 study for PubMed the incidence was
- 0.63 per 100,000 in all students (6 in one million)
- 1.14 per 100,000 athletes (10 in one million)
- 0.31 per student non-athletes (3 in one million)
- The relative risk of SCA in student athletes vs non-athletes was 0.65
- There is a significantly higher risk of SCA for boys than girls

Leading causes of sudden death among high school and college athletes, according to the NCAA (on CBS News, June 28, 2012)* are heat stroke, heart disease and traits associated with sickle cell anemia. Prevention of sudden death, the same study concludes, is associated with more advanced cardiac screening with attention to medical histories and birth records, improved emergency procedures, and good coaching and conditioning practices.

Part III - WHAT ARE THE WARNING SIGNS AND SYMPTOMS?
Although SCA happens unexpectedly, some people may have signs or symptoms, such as: fainting or seizures during exercise; unexplained shortness of breath; dizziness; extreme fatigue; chest pains; or racing heart. These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

Sudden cardiac arrest is a medical emergency. If not treated immediately, it causes sudden cardiac death. With fast, appropriate medical care, survival is possible. Administering cardiopulmonary resuscitation (CPR) — or even just compressions to the chest — can improve the chances of survival until emergency personnel arrive. (http://www.mayoclinic.org/diseases-conditions/sudden-cardiac-arrest/basics/)

WHAT ARE THE RISKS OF PRACTICING OR PLAYING AFTER EXPERIENCING THESE SYMPTOMS?
There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

Removal from Play
Any student-athlete who shows signs or symptoms of SCA must be removed from athletic activity and referred to a licensed health care professional trained specifically in the treatment of cardiac care. The symptoms can happen before, during or after activity.

Return to Play
Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed and written clearance be provided by a licensed medical provider.
To summarize:

- SCA is, by definition, sudden and unexpected.
- SCA can happen in individuals who appear healthy and have no known heart disease.
- Most people who have SCA die from it, usually within minutes.
- Rapid treatment of SCA with a defibrillator can be lifesaving.
- Training in recognition of signs of cardiac arrest and SCA, and the availability of AEDs and personnel who possess the skills to use one, may save the life of someone who has had an SCA.

(National Heart, Lung, and Blood Institute)

I have read and understand this document the “Student & Parent Informed Consent Form” and understand the severities associated with sudden cardiac arrest and the need for immediate treatment of any suspected condition.

Student name: ______________________________ Date _____ Signature ____________________________

(Print Name)

I authorize my child to participate in ______________________________ for school year ______________________

(Sport/Activity)

Parent/Guardian name: ______________________________ Date _____ Signature ____________________________

(Print Name)

Sources:
Simons Fund - http://www.simonsfund.org/
Connecticut Technical High School System
Interscholastic Permission

School: ___________________________ Date Received: ___________________________

PARENT/GUARDIAN: PLEASE COMPLETE
This form plus a physical exam form must be on file with the School Nurse before the student may practice or play a sport. Physical exams are valid for 13 months from the date of exam. A new permission form is also required every 13 months.

Section 1: To Be Completed by Student

Student Agreement:

Name: ___________________________ Date of Birth: ___________________________

Grade: ________ Shop: ________ Sport(s): ________

This application to compete in interscholastic athletics for the above school is entirely voluntary on my part. I certify that I have not violated any of the eligibility rules and regulations of the Connecticut Interscholastic Athletic Conference (CIAC).

Signature of Student: ___________________________ Date: ___________________________

Section 2: To Be Completed by Parent/Guardian

Parent/Guardian’s Permission: I give my consent for the above student to participate in interscholastic athletics and to accompany the team, as a member, on trips to any interscholastic games and consent to the necessary transportation for such trips.

I understand that high school athletics involve the potential for injury which is inherent with any sport. I am aware that even with the best coaching, supervision, protective equipment and strict observation of the rules that there is still a potential for injury. On rare occasions, injuries could result in total disability or death.

Signature of Parent/Guardian: ___________________________ Date: ___________________________ Email Address: ___________________________

Home Address: ___________________________ Phone: (H) ___________________________ (W) ___________________________ (C) ___________________________

Emergency Contact #1 Info: Name: ___________________________ Relationship: ___________________________

Address: ___________________________ Phone: (H) ___________________________ (W) ___________________________ (C) ___________________________

Emergency Contact #2 Info: Name: ___________________________ Relationship: ___________________________

Address: ___________________________ Phone: (H) ___________________________ (W) ___________________________ (C) ___________________________

(Street address, city, zip code)
Acknowledgement Form, Student Transportation Vehicle Rider's Handbook

Student Transportation Use and Access Agreement
By signing the student/parent acknowledgment signature page of the student handbook, I, as a rider of the CTHSS's Student Transportation Vehicle, acknowledge that I have read, accept and agree to abide by the Student Transportation Use and Access Agreement Policy of the CTHSS and with the following preconditions of my use of the CTHSS Student Transportation Use and Access Agreement Policy:

As parent/guardian of __________________________ I hereby (student's name) acknowledge that I have read the CTHSS Student Transportation Vehicle Rider's Handbook 2010-2011 and agree to discuss the rules and procedures with my child/children. I understand that transportation of my child/children is a privilege and will treat it as such. I further understand that if my child/children miss the Student Transportation Vehicle either to school or home, I am responsible for their transportation. My child/children agree to follow all rules and policies in the handbook.

Parent/guardian signature: __________________________

Printed name: __________________________

Student signature: __________________________

Printed name: __________________________

Date: __________________________
# State of Connecticut Department of Education

## Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-20e). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

<table>
<thead>
<tr>
<th>Student Name (Last, First, Middle)</th>
<th>Birth Date</th>
<th>☐ Male ☐ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (State, Town and ZIP code)</td>
<td>Home Phone</td>
<td>Cell Phone</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Name (Last, First, Middle)</th>
<th>Race/Ethnicity</th>
<th>☐ Black, not of Hispanic origin ☐ White, not of Hispanic origin ☐ Asian/Pacific Islander</th>
</tr>
</thead>
<tbody>
<tr>
<td>School/Grade</td>
<td>☐ American Indian/Alaskan Native ☐ Hispanic/Latino ☐ Other</td>
<td></td>
</tr>
</tbody>
</table>

Health Insurance Company/Number* or Medicaid/Number*

Does your child have health insurance? Y N
Does your child have dental insurance? Y N
If your child does not have health insurance, call 1-877-CT-HUSKY

* If applicable

## Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle Y if "yes" or N if "no." Explain all "yes" answers in the space provided below.

<table>
<thead>
<tr>
<th>Any health concerns</th>
<th>Y N</th>
<th>Hospitalization or Emergency Room visit</th>
<th>Y N</th>
<th>Conjunction</th>
<th>Y N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies to food or bee stings</td>
<td>Y N</td>
<td>Any broken bones or dislocations</td>
<td>Y N</td>
<td>Fainting or blacking out</td>
<td>Y N</td>
</tr>
<tr>
<td>Allergies to medication</td>
<td>Y N</td>
<td>Any muscle or joint injuries</td>
<td>Y N</td>
<td>Chest pain</td>
<td>Y N</td>
</tr>
<tr>
<td>Any other allergies</td>
<td>Y N</td>
<td>Any neck or back injuries</td>
<td>Y N</td>
<td>Heart problems</td>
<td>Y N</td>
</tr>
<tr>
<td>Any daily medications</td>
<td>Y N</td>
<td>Problems running</td>
<td>Y N</td>
<td>High blood pressure</td>
<td>Y N</td>
</tr>
<tr>
<td>Any problems with vision</td>
<td>Y N</td>
<td>&quot;Moor&quot; (past 1 year)</td>
<td>Y N</td>
<td>Bleeding more than expected</td>
<td>Y N</td>
</tr>
<tr>
<td>Use contacts or glasses</td>
<td>Y N</td>
<td>Has only 1 kidney or testicle</td>
<td>Y N</td>
<td>Problems breathing or coughing</td>
<td>Y N</td>
</tr>
<tr>
<td>Any problems hearing</td>
<td>Y N</td>
<td>Excessive weight gain/loss</td>
<td>Y N</td>
<td>Any smoking</td>
<td>Y N</td>
</tr>
<tr>
<td>Any problems with speech</td>
<td>Y N</td>
<td>Dental braces, caps, or bridges</td>
<td>Y N</td>
<td>Asthma treatment (past 3 years)</td>
<td>Y N</td>
</tr>
</tbody>
</table>

Family History

Any relative ever have a sudden unexplained death (less than 50 years old) | Y N | Diabetes | Y N |
|--------------------------------|-----|-------------|-----|
Any immediate family members have high cholesterol | Y N | ADR/ADD | Y N |

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any medications your child will need to take in school:

All medications taken in school require a separate Medication Authorization Form signed by a health care provider and parent/guardian.

I give permission for release and exchange of information on the form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian: ____________ Date: ____________

To be maintained in the student's Cumulative School Health Record.
Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name ___________________________ Birth Date ___________ Date of Exam ___________

☐ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

<table>
<thead>
<tr>
<th>*Height in./%</th>
<th>*Weight lbs./%</th>
<th>BMI</th>
<th>% Pulse</th>
<th>*Blood Pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>Describe Abnormal</td>
<td>Ortho</td>
<td>Normal</td>
<td>Describe Abnormal</td>
</tr>
</tbody>
</table>

- Neurologic
- HEENT
- *Gross Dental
- Lymphatic
- Heart
- Lungs
- Abdomen
- Genitalia/ hernia
- Skin

*Postural: ☐ No spinal abnormality: ☐ Spinal abnormality:
- ☐ Mild: ☐ Moderate: ☐ Marked: ☐ Referral made

Screenings

*Vision Screening

<table>
<thead>
<tr>
<th>Type:</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>With glasses</td>
<td>20/20</td>
<td>20/20</td>
</tr>
<tr>
<td>Without glasses</td>
<td>20/20</td>
<td>20/20</td>
</tr>
</tbody>
</table>

☐ Referral made: ☐ Referral made

*Auditory Screening

<table>
<thead>
<tr>
<th>Type:</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Pass</td>
<td>☐ Pass</td>
<td>☐ Fail</td>
</tr>
</tbody>
</table>

☐ Referral made

TB: ☐ High-risk group! ☐ No ☐ Yes

PPD date read: ☐ Results: ☐ Treatment:

IMMUNIZATIONS

☐ Up to Date or ☐ Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED

*Chronic Disease Assessment:

- Asthma ☐ No ☐ Yes: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise induced
- If yes, please provide a copy of the Asthma Action Plan to School

- Anaphylaxis ☐ No ☐ Yes: ☐ Food ☐ Insects ☐ Latex ☐ Unknown source
- Allergies ☐ Yes: ☐ Other
- If yes, please provide a copy of the Emergency Allergy Plan to School

- History of Anaphylaxis ☐ No ☐ Yes: ☐ Epi Pen required ☐ No ☐ Yes

- Diabetes ☐ No ☐ Yes: ☐ Type I ☐ Type II
- Other Chronic Disease:

- Seizures ☐ No ☐ Yes, type:

☐ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience. Explain:

- Daily Medications (specify):

- This student may: ☐ participate fully in the school program
  - ☐ participate in the school program with the following restriction/adaptation:

- This student may: ☐ participate fully in athletic activities and competitive sports
  - ☐ participate in athletic activities and competitive sports with the following restriction/adaptation:

☐ Yes ☐ No: Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness. Is this the student’s medical home? ☐ Yes ☐ No ☐ I would like to discuss information in this report with the school nurse.

Signature of health care provider: ___________________________ Date signed: ___________

Printed/Handwritten Provider Name and Phone Number: ___________________________
**Immunization Record**

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.*

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
<th>Dose 4</th>
<th>Dose 5</th>
<th>Dose 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP/DTaP</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>DT/td</td>
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</tr>
<tr>
<td>Td</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Required for 7th grade entry</td>
</tr>
<tr>
<td>IPV/OPV</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Required K-12th grade</td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Required K-12th grade</td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Required K-12th grade</td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Required K-12th grade</td>
</tr>
<tr>
<td>HBV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PK and K (Students under age 5)</td>
</tr>
<tr>
<td>Hep A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PK and K (birth 1/1/2007 or later)</td>
</tr>
<tr>
<td>Hep B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Required PK-12th grade</td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 doses required for K &amp; 7th grade as of 8/1/2011</td>
</tr>
<tr>
<td>PCV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PK and K (birth 1/1/2007 or later)</td>
</tr>
<tr>
<td>Meningoococcal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Required for 7th grade entry</td>
</tr>
<tr>
<td>HPV</td>
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<td>Flu</td>
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<td>*NC students 24-59 months old – given annually</td>
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<td>Other</td>
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Disease Hx of above (Specify) (Date) (Confirmed by)

Exemption

Religious | Medical: Permanent | Medical: Temporary | Date
Recertify Date | Recertify Date | Recertify Date

**Immunization Requirements for Newly Enrolled Students at Connecticut Schools**

**Kindergarten**
- DTaP: At least 4 doses. The last dose must be given on or after 4th birthday.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart—1st dose on or after the 1st birthday.
- Hib: 1 dose on or after 1st birthday (Children 6 months and older do not need proof of Hib vaccination).
- Pneumococcal: 1 dose on or after 1st birthday (born 1/1/2007 or later and less than 5 years old).
- Hep A: 2 doses given six months apart—1st dose on or after 1st birthday.
- Hep B: 3 doses—the last dose on or after 24 weeks of age.
- Varicella: For students enrolled before August 1, 2011, 1 dose given on or after 1st birthday; for students enrolled on or after August 1, 2011 1 dose given 3 months apart—1st dose on or after 1st birthday or verification of disease.

**Grades 1-6**
- DTaP/Td/Td: At least 4 doses. The last dose must be given on or after 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diptheria-containing vaccine.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart—1st dose on or after 1st birthday.
- Hib: 1 dose on or after 1st birthday.
- Pneumococcal: 1 dose on or after 1st birthday or verification of disease.
- Meningoococcal: one dose for students enrolled in 7th grade.
- Hep B: 3 doses—the last dose on or after 24 weeks of age.
- Varicella: 2 doses given 3 months apart—1st dose on or after 1st birthday or verification of disease.

**Grades 7-12**
- Td: At least 3 doses. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diptheria containing vaccine one of which should be Td.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart—1st dose on or after 1st birthday.
- Hib: 1 dose on or after 1st birthday.
- Pneumococcal: 1 dose on or after 1st birthday or verification of disease.
- Meningoococcal: one dose for students enrolled in 7th grade.
- Hep B: 3 doses—the last dose on or after 24 weeks of age.
- Varicella: 2 doses given 3 months apart—1st dose on or after 1st birthday or verification of disease.

* Verification of disease. Confirmation in writing by a MD, PA, or APN that the child has a previous history of disease, based on family or medical history.