2021-2022 Athlete Eligibility Packet Sign-off

Student Name:_____ Grade:_____ Sport:_____

Date of Birth: _____

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:_____

GRASSO TECHNICAL HIGH SCHOOL
Student and Parent Concussion Informed Consent Form
2021-2022

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: *Concussions: 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.
5. Current best practices in the prevention and treatment of a concussion.

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
- 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

Symptoms of a concussion may include (i.e. what the athlete reports):

- Headache or dizziness
- Nausea or vomiting
- Blurred or double vision
- 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)

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

* 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:

1. NFHS. Concussions. 2008 NFHS Sports Medicine Handbook (Third Edition). 2008: 77-82. http://www.nfhs.org. http://journals.lww.com/cjsportsmed/Fulltext/2009/05000/Consensus_Statement_on_Concussion_in_Sport_3rd.1.aspx.
2. Centers for Disease Control and Prevention. *Heads Up: Concussion in High School Sports*. http://www.cdc.gov/NCIPC/tbi/Coaches_Tool_Kit.htm.
3. CIAC Concussion Central - http://concussioncentral.ciacsports.com/

Resources:

CDC. *Injury Prevention & Control: Traumatic Brain Injury*. Retrieved on June 1, 2015. http://www.cdc.gov/TraumaticBrainInjury/index.html
CDC. *Heads Up: Concussion in High School Sports Guide for Coaches*. Retrieved on June 1, 2015. http://www.cdc.gov/headsup/highschoolsports/coach.html
CDC. *Heads Up: Concussion* materials, fact sheets and online courses. Retrieved on June 6, 2015. http://www.cdc.gov/headsup/

GRASSO TECHNICAL HIGH SCHOOL
Sudden Cardiac Arrest
Student & Parent Informed Consent Form
2021-2022

This *Parent and Legal Guardian Sudden Cardiac Arrest Awareness Informed Consent Form* 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 CADIAC 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 go into an unstable rapid rhythm.

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.
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/)

PART 3 - WHAT ARE THE WARNING SIGNS AND SYMPTOM of Sudden Cardiac Arrest?
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.

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.
Any student-athlete who shows signs or symptoms of SCA must be immediately removed from the athletic activity.

Part 4: *What should occur when a person experiences Sudden Cardiac Arrest?*
When a person experiences SCA, three actions should be taken immediately:

1st: **Get Help!** Call out for assistance and call 911.

2nd: **Start CPR!** Begin hands-only CPR.

3rd: **Attach and activate an Automated External Defibrillator** (**AED)!** An AED should be attached, activated and the user should follow the prompts. The AED will be able to determine if a shock should be given to the heart or if CPR should be continued without a shock. If the AED determines that a shock should be given, it will give instructions on how to proceed.

Only CPR and AED use have been proven to help a person get out of a cardiac arrest. For every minute a person does not receive a shock, the chances of survival goes down by 10% per minute. Keep in mind that the average response time for emergency medical services (EMS) is approximately 5-8 minutes. The AED will not allow the user to deliver an electric shock if it is not clinically applicable. The person using the AED can attach the device to the person suffering the SCA, turn it on and push the shock button, but the AED will not allow a shock to be delivered if it is unwarranted. No harm can be done by applying an AED to an individual.

RETURN TO PLAY
Before returning to play, the athlete must be evaluated by a licensed medical provider. Following the evaluation, written clearance, signed by the licensed medical provider, must be given prior to the student-athlete engaging in any athletic activity.

Part 5*: Local Board of Education Policy regarding Sudden Cardiac Arrest*
******* Refer to all Above Procedures*******

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)
http://www.nhlbi.nih.gov/health/health-topics/topics/scda

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/Resources:

Simons Fund - http://www.simonsfund.org/

Pennsylvania Department of Health - http://www.simonsfund.org/wp-content/uploads/2012/06/Parent-Handout- SCA.pdf

Mayo Clinic - http://www.mayoclinic.org/diseases-conditions/sudden-cardiac-arrest/basics/definition/con- 20042982

National Heart, Lung and Blood Institute (NHLBI) - http://www.nhlbi.nih.gov/health/health-topics/topics/scda

American Heart Association (AHA) - http://www.heart.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 supervised 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) _____
(street address, city, zip code)

Emergency Contact #1 Info: Name: _____ Relationship_____

Address: _____ Phone: (H) _____ (W) _____ (C) _____
(street address, city, zip code)

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 10-206). 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

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
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.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
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	ADHD/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 this 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

HAR-3 REV. 4/2011

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

***Height** ____ in. / ____% ***Weight** ____ lbs. / ____% **BMI** ____ / ____% **Pulse** ____ ***Blood Pressure** ____ / ____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

*Vision Screening		
Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/
❑ Referral made		

*Auditory Screening		
Type:	Right	Left
	❑ Pass	❑ Pass
	❑ Fail	❑ Fail
❑ Referral made		

	Date
Lead:	
*HCT/HGB:	
*Speech (school entry only)	
Other:	

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 *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 MD / DO / APRN / PA Date Signed Printed/Stamped *Provider* Name and Phone Number

Student Name: _____ Birth Date: _____ HAR-3 REV. 4/2011

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.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required for 7th grade entry	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			PK and K (born 1/1/2007 or later)	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			2 doses required for K & 7th grade as of 8/1/2011	
PCV	*				PK and K (born 1/1/2007 or later)	
Meningococcal	*				Required for 7th grade entry	
HPV						
Flu	*				* PK students 24-59 months old – given annually	
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Exemption

Religious ____ **Medical: Permanent** ____ **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 day apart – 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after 1st birthday (Children 5 years 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 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 1-6

- DTaP /Td/Tdap: 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-diphtheria 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 the 1st birthday.
- Hep B: 3 doses – the last dose on or after 24 weeks of age.
- Varicella: 1 dose on or after the 1st birthday or verification of disease*.

GRADE 7

- Tdap/Td: 1 dose of Tdap for students 11 yrs. or older enrolled in 7th grade who completed their primary DTaP series; For those students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are needed, one of which must be Tdap.
- 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.
- Meningococcal: 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 8-12

- Td: At least 3 doses. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine one of which should be Tdap.
- 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.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart or verification of disease*.

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

Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped *Provider* Name and Phone Number