Start Date: ______________________

REGISTRATION INFORMATION

Youth's Name: ______________________________
Last First Middle

Home Phone Number: ______________________ Date of Birth: ______________________

Home Address: ______________________________

Male ☐ Female: ☐ Hair Color: ______________________ Eye Color: ______________________

Parent/Guardian's Name: ______________________________
Last First Middle

Address (if different than youth): ______________________________

Place of Employment: ______________________________
Name/Phone No. Address/City/State

Email Address: ______________________________

Parent/Guardian's Name: ______________________________
Last First Middle

Address (if different than youth): ______________________________

Place of Employment: ______________________________
Name/Phone No. Address/City/State

Email Address: ______________________________

PERSON'S AUTHORIZED TO PICK UP YOUTH (include self):

1. ______________________ ______________________
Name/Phone No. Address/City/State

2. ______________________ ______________________
Name/Phone No. Address/City/State

3. ______________________ ______________________
Name/Phone No. Address/City/State

Youth's Doctor: ______________________ ______________________
Name/Phone No. Address/City/State

Youth's Dentist: ______________________ ______________________
Name/Phone No. Address/City/State

Youth's Insurance Provider: ______________________ **Group No. & I.D.** ______________________

Emergency contact to call if parent cannot be reached and medical authorization may be obtained:

Name: ______________________ Phone No.: ______________________

Address: ______________________ Relationship: ______________________

Name: ______________________ Phone No.: ______________________

Address: ______________________ Relationship: ______________________

Hospital of Choice: ______________________________
Name/Phone No. Address/City/State

Any Allergies or Health Problems we need to be aware of: ______________________________

____

Special Instructions: ______________________________

Emergency Medical Authorizations: I, ______________________, hereby give permission to the City of Thornton Staff to call a doctor for medical or surgical care for my youth, ______________________, should an emergency situation arise. It is understood that a conscious effort will be made to locate my spouse or me before any action will be taken, but if it is not possible to locate us, this expense will be excepted by us.

I understand that it is my responsibility to apply sunscreen to my youth before bringing him/her to camp.

______________________ ______________________
Signature of Parent or Legal Guardian Date

EMERGENCY INFORMATION CARD

Youth's Name ____

Parent's Name ____

Address ____

Home Phone ______________ Age:______ Eye Color ______________ Hair Color ______________

Allergies ____

____

____

Special Needs or Health Notes and Special Instructions ______________________________

____

____

Name of Preferred Hospital ____

IN CASE OF EMERGENCY CALL:

First: ____

Name | Relationship | Home Phone | Work Phone

Second: ____

Name | Relationship | Home Phone | Work Phone

Third: ____

Name | Relationship | Home Phone | Work Phone

PICK-UP LIST:

____

Name | Relationship | Home Phone | Work Phone

____

Name | Relationship | Home Phone | Work Phone

____

Name | Relationship | Home Phone | Work Phone

City of Thornton

FAMILY QUESTIONNAIRE

Every line must be filled in!

In order for us to best help meet your child's needs, please answer the following questions. Our goal is to meet the needs of all the campers.

Participant's Name ______________________________ Nickname ______________________________

1. What are your child's interests and/or what does your child enjoy doing?______________________________

   ____

2. Does your child have any issues participating in large group activities? Yes No

   If *Yes*, please explain______________________________

   ____

3. Are there any activities or foods your child is unable to participate in due to medical, physical, social or religious reasons?

   Please explain: ______________________________

   ____

4. How does your child express anger or react to frustration? What strategy works best to help calm your child? (i.e. taking a break, asking for help, counting to 10, change location, etc.)?

   ____

   ____

   ____

5. What strategies are used at home or school to address disruptive behavior? ______________________________

   ____

   ____

6. What items or activities are used to help motivate your child if they are struggling with structure?

   ____

   ____

7. When your child refuses to follow instruction, how do you address this? What items, phrases, or activities are used to reward your child when they follow instruction?______________________________

   ____

8. Is there any other information we should know to best work with your child (therapy your child has, special needs, temperament, what you would like to see take place in class, etc.)?

   ____

   ____

   ____

City of Thornton

PARTICIPANT PERMISSIONS SHEET

Every line must be filled in!

Participant's Name ____________________

PG MOVIES

I give my permission for my youth to watch PG movies during camp. All of the movies are screened BEFORE they are shown at camp.

____________________ ____________________

Signature of Parent or Legal Guardian Date

PG-13 MOVIES

I give my permission for my youth to watch PG-13 movies during camp. All of the movies are screened BEFORE they are shown at camp.

____________________ ____________________

Signature of Parent or Legal Guardian Date

NATURE WALKS AND WALKING FIELD TRIPS

I allow my youth to participate in supervised nature walks and walking field trips within one mile area surrounding the Thornton Community Center.

____________________ ____________________

Signature of Parent or Legal Guardian Date

FIELD TRIPS AND PARTICIPATION

I give permission for my child to go on field trips and participate in program activities on site and away from the Thornton Community Center, whether on foot or by school or RTD bus, with the following exceptions (if any):

____________________ ____________________

Signature of Parent or Legal Guardian Date

MEDIA RELEASE

I hereby grant the city of Thornton Recreation Department permission to utilize photos for media and promotion for use with Thornton Recreation Programs.

____________________ ____________________

Signature of Parent or Legal Guardian Date

ARTS & CRAFTS

I allow my youth to participate in various arts and crafts during camp. I understand they will be using various tools and equipment including but not limited to scissors, glue, plaster, paint, small beads and markers.

____________________ ____________________

Signature of Parent or Legal Guardian Date

CELL PHONE USE

I would like my youth to bring his/her cell phone to camp. We have discussed the policy and agree that, if staff feels that cell phone use interferes with camp activities, the phone will be confiscated and I will pick it up when I pick my youth up from camp.

____________________ ____________________

Signature of Parent or Legal Guardian Date

If you have any questions or concerns about any of these matters, please contact Christine Sanford at 720-977-5963.

City of Thornton

PARENT/GUARDIAN & PARTICIPANT CONTRACT

Every line must be filled in!

- We have read and understand the policies and procedures outlined in the parent information packet.

  ______________________________/ ____________________________
  Parent or Legal Guardian's Initials   Participant's Initials

- We will abide by the rules set by the camp staff in order to ensure the safety and well-being of all participants and their families.

  ______________________________/ ____________________________
  Parent or Legal Guardian's Initials   Participant's Initials

- We understand the process followed should disciplinary measures be necessary.

  ______________________________/ ____________________________
  Parent or Legal Guardian's Initials   Participant's Initials

PARENT/LEGAL GUARDIAN AND PARTICIPANT NEED TO INITIAL ABOVE AND SIGN BELOW.

____ ____
Signature of Parent or Legal Guardian   Date

____ ____
Signature of Participant   Date

REFUND AGREEMENT

I, ____, parent/guardian of ____

have read and understand the Refund Policy: *"Refunds will not be given after 5 p.m., May 1, 2020."*
The full policy is located on page 8 check page of the Licensed Program Handbook and page 72 of the Winter/Spring 2020 Thornton Activities Guide.

____ ____
Signature of Parent or Legal Guardian   Date

I have read and understand the payment policy found in the *Spring Break Camp, Adventure Club* and *My Escape* addendum. I understand that a $15 late fee will be assessed for any deposit program payment made 5 days late. If payments are two weeks past due and/or habitually late, I understand that my youth's space will be forfeited.

____ ____
Signature of Parent or Legal Guardian   Date

If youth is not picked up 5 minutes after the program ends for the day, staff will start making necessary phone calls from your information form. A youth will never be left alone in the classroom.

- You will be charged $1 per minute that you are late.
- Payment must be made at the front desk before your youth can return to camp.
- You will be given a receipt for your payment. You must show this receipt to camp staff at sign in.
- If the parents/guardians or emergency contacts can not be reached 30 minutes after class has elapsed, staff will then turn the youth over to the police department and Adams County Social Services. Every reasonable effort will be made to contact the parents/guardians or authorized contact people before this time.

____ ____
Signature of Parent or Legal Guardian   Date

City of Thornton

SUN PROTECTION AUTHORIZATION SHEET

Every line must be filled in!

I hereby authorize a camp staff member to supervise and/or assist in applying sunscreen to:

____

Participant's name

The city of Thornton provides Rocky Mountain brand sunscreen for all participants. If your youth can not wear this brand, please provide him/her with a labeled personal bottle of sunscreen.

SELECT ONE:

________ I agree to allow the camp staff to use Rocky Mountain brand sunscreen on my youth.

________ I do not want the Rocky Mountain brand sunscreen to be used on my youth and I agree to supply my youth with sunscreen to be applied according to the instructions below.

Camp staff supervise/assist with the application of sunscreen to bare surfaces including the face, tops of ears, bare shoulders, arms, legs, back and tops of feet. Staff supervise/assist the application of sunscreen to all exposed skin. **Sunscreen is applied when we plan on being outdoors for more than 30-minutes and reapplied every hour.**

If you feel this guideline is not sufficient for your youth, please indicate specific instructions below.

SPECIAL INSTRUCTIONS ____

____

____

____

____ ______________________

Signature of Parent of Legal Guardian Date

GENERAL HEALTH APPRAISAL FORM

PARENT please complete AND SIGN

Child's Name: ______________________ **Birthdate:** ______________

Allergies: ❑ None or Describe ______________________

Type of Reaction ______________________

Diet: ❑ **Breast Fed** ❑ **Formula** ______________ ❑**Age Appropriate**

❑**Special Diet** ______________________

Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep.

❑ **Preventive creams/ointments/sunscreen may be applied as requested in writing by parent unless skin is broken or bleeding.**

I, ______________________ give consent for my child's care health provider, school child care or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (& applicable attachments) to my child's school, child care or camp personnel. FAX #: ______________ **DATE:** ______________

Parent/Guardian Signature ______________________

HEALTH CARE PROVIDER: Please Complete After Parent Section Completed

Date of Last Health Appraisal: ______________ **Weight @ Exam:** ______________

Physical Exam: ❑ **Normal** ❑ **Abnormal** (Specify any physical abnormalities) ______________________

Allergies: ❑ None or Describe ______________ Type of Reaction ______________

Significant Health Concerns: ❑Severe Allergies ❑Reactive Airway Disease ❑Asthma ❑Seizures ❑Diabetes ❑Hospitalizations ❑Developmental Delays ❑Behavior Concerns ❑Vision ❑Hearing ❑Dental ❑Nutrition ❑ Other ______________

Explain above concern (if necessary, include instructions to care providers): ______________________

Current Medications/Special Diet: ❑ None or Describe ______________________

Separate medication authorization form is required for medications given in school, child care or camp

For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization) PLEASE CHOOSE ONE PRODUCT

❑Acetaminophen (Tylenol) may be given for pain or fever over 102 degrees every 4 hours as needed

Dose ______________ or see the attached age-appropriate dosage schedule from our office

OR ❑Ibuprofen (Motrin, Advil) may be given for pain or for fever over 102 degrees every 6 hours as needed

Dose ______________ or see the attached age-appropriate dosage schedule from our office

Immunizations: ❑Up-to-Date ❑ See attached immunization record ❑Administered today: ______________

Health Care Provider: Complete

****Screenings Performed:** ❑**Vision:** ❑Normal ❑Abnormal ❑**Hearing:** ❑Normal ❑Abnormal ❑**Dental:** ❑Normal ❑Abnormal-

Recommended Follow-up ______________________

Provider Signature

Next Well Visit: ❑ Per AAP guidelines* or ❑ Age ________

This child is healthy and may participate in all routine activities in school sports, child care or camp program. Any concerns or exceptions are identified on this form.

____

Signature of Health Care Provider (certifying form was reviewed) Date: ____________

Office Stamp

Or write Name, Address, Phone, #

The Colorado Chapter of the American Academy of Pediatrics (AAP) and Healthy Child Care Colorado have approved this form. 04/07

*The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

Copyright 2007 Colorado Chapter of the American Academy of Pediatrics

City of Thornton

Every line must be filled in!

MEDICATION ADMINISTRATION

This form only needs to be filled out if medication is being administered by staff.

The parent/guardian of (Child's name) ______________________________

ask that summer staff give the following medication (Name of medicine and dosage) ______________________________

at ____________ a.m./p.m. to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The Program agrees to administer medication prescribed by a licensed health care provider.

- It is the parent/guardian's responsibility to furnish the medication.
- The parent agrees to pick up expired or unused medication within one week of notification by staff.
- Prescription medication/s must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.
- Over-the-counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.
- By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or camp staff delegated to administer medication.

______________________________ ______________________________
Signature of Parent or Legal Guardian Date

______________________________ ______________________________
Print name of Parent/Guardian Work Phone

______________________________ ______________________________
Home Phone Cell Phone

HEALTH CARE PROVIDER AUTHORIZATION-TO-ADMINISTER MEDICATION IN CHILD CARE

Child's Name ______________________________ Birthdate: ______________________________

Medication: ______________________________

Dosage: ______________________________ Route: ______________________________

To be given at the following time(s): ______________________________

Special Instructions: ______________________________

Purpose of medication: ______________________________

Side effects that need to be reported: ______________________________

Starting Date: ______________________________ Ending Date: ______________________________

____
Signature of Health Care Provider with Prescriptive Authority License Number

______________________________ ______________________________
Date Phone Number

City of Thornton

COLORADO SCHOOL ASTHMA CARE PLAN

Every line must be filled in!

Please ask the pharmacist for a separate medicine bottle to keep at summer camp. Thank you!

Name	Birthdate
Teacher	Grade
Parent/Guardian	Cell Phone
Home Phone	Work Phone
Other Contact	Phone
Preferred Hospital	

TRIGGERS: ☐ Weather (cold air, wind) ☐ Illness ☐ Exercise ☐ Smoke ☐ Dog/Cat ☐ Dust ☐ Mold ☐ Pollen

Other____

GREEN ZONE: Pretreatment Steps for Exercise (Health provider please complete section)

☐ Give 2 puffs of rescue med *(name)* ______________________ 15 minutes before activity.
(Circle indication: Phys Ed class, exercise/sports, recess)
Explanation____

☐ Repeat in 4 hours if needed for additional or ongoing physical activity

YELLOW ZONE: Sick Uncontrolled Asthma (Health provider complete dosing for rescue medication)

IF YOU SEE THIS:	DO THIS:
• Difficulty breathing • Wheezing • Frequent cough • Complains of chest tightness • Unable to tolerate regular activities but still talking in complete sentences • Other	• Stop physical activity • Give rescue med *(name)* ______________ ☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ Other ___________ • If no improvement in 10-15 minutes, repeat use of rescue med. ☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ Other ___________ • If student's symptoms do not improve or worsen, call 911 • Stay with student and maintain sitting position • Call parents/guardians and school nurse • Student may resume normal activities once feeling better

RED ZONE: EMERGENCY SITUATION (Health provider complete dosing for rescue medication)

IF YOU SEE THIS:	DO THIS:
• Coughs constantly • Struggles or gasps for breath • Trouble talking (can speak only 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips or fingernails are gray or blue • ↓Level of consciousness	• Give rescue med *(name)* ______________ ☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ Other ___________ • If no improvement in 10-15 minutes, repeat use of rescue med. ☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ Other ___________ • Call 911 Inform attendant the reason for the call is asthma • Call parents/guardians and school nurse • Encourage student to take slower deeper breaths • Stay with student and remain calm • *School personnel should not drive student to hospital*

INSTRUCTIONS for RESCUE INHALER USE: (HEALTH PROVIDER: PLEASE CHECK APPROPRIATE BOX(ES)

☐ Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently

☐ Student is to notify his/her designated school health officials after using inhaler

☐ Student needs supervision or assistance to use his/her inhaler.

If not self carry, the inhaler is located ______________________________

☐ Student has life threatening allergy, the epipen is loca\ed ______________________________

______________________________ ______________________________
Signature of Health Care Provider Date

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.

______________________________ ______________________________
Signature of Parent or Legal Guardian Date

______________________________ ______________ ☐ 504 Plan or IEP
Signature of School Nurse Date

Allergy and Anaphylaxis Action Plan and Medication Orders

Place child's photo here

To be completed by healthcare provider

Student's Name: ______________________ D.O.B. ________ Grade: ________
School: ______________________ Teacher: ______________________
ALLERGY TO: ______________________
____
History: ______________________
____

Asthma: ☐ YES (Higher risk for severe reaction) ☐ NO

◊ STEP 1: TREATMENT

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   - Antihistamine
   - Inhaler (bronchodilator) if asthma

*Antihistamine & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

DOSAGE

Epinephrine: inject intramuscularly using autoinjector (check one): ☐ **0.3 mg** ☐ **0.15 mg**
☐ Administer 2nd dose if symptoms do not improve in ____________ minutes
Antihistamine: (brand and dose)______________________
If Asthmatic: (brand and dose)______________________

Student has been instructed and is capable of carrying and self administering own medication. ☐ Yes ☐ No
Provider (print) ______________________ Phone Number: ____________
Provider's Signature: ______________________ Date: ____________

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: ______________________ Phone Number: ______________________
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. ______________________ 1) ____________ 2) ____________
   b. ______________________ 1) ____________ 2) ____________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS
I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: ______________________ Date: ____________

School Nurse: ______________________ Date: ____________

Student Name: ______________________________ **DOB:** ____________________

TRAINED STAFF MEMBERS

1. ______________________________ Room__________
2. ______________________________ Room__________
3. ______________________________ Room__________
4. ______________________________ Room__________
5. ______________________________ Room__________

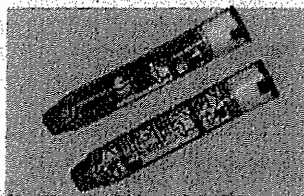
Self-carry contract on file. ☐Yes ☐No Medication located in: ____________________

Additional information:____

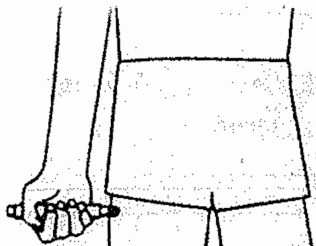
EpiPen® and EpiPen® Jr. Directions

Expiration date: __________

- Pull off blue activation cap.



- Hold orange tip near outer thigh (always apply to thigh)

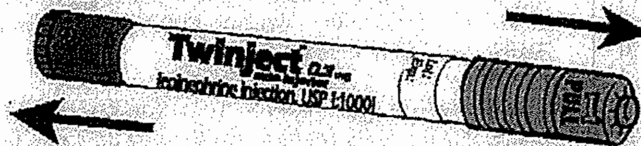


- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Expiration date: __________

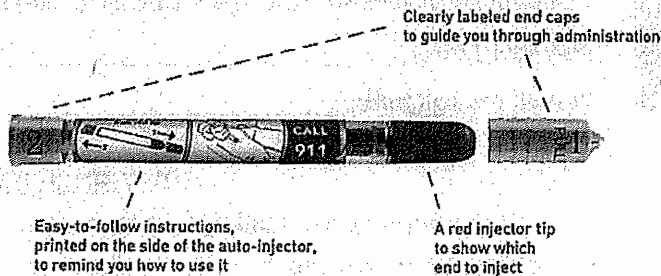
- Remove caps labeled "1" and "2."



- Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

Adrenaclick 0.3 mg. and Adrenaclick 0.15 mg. Directions

Expiration date: __________



Once epinephrine is used, call 911. Student should remain lying down or in a comfortable position.

____

____

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

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 ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: ______________________ **Date of birth:** ____________

Parent/guardian: ______________________

Required vaccines

	Immunization date(s) MM/DD/YY						Titer date* MM/DD/YY
Hep B 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	

*A positive laboratory titer report must be provided to the school to document immunity.

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

Recommended vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

Health care provider signature or stamp: ______________________ Date: ____________

Student is current on required immunizations for age (circle one): Yes No

OR

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: ____________

Advancing Colorado's health and protecting the places we live, learn, work and play

Dear parents/guardians of students in Colorado kindergarten – 12th grade schools for the 2020-21 school year:

We know you're thinking of all the things you need to do to make sure your student is ready for school. Getting vaccinated is an important part of their school readiness and keeps children from catching and spreading diseases that can make them sick. We wish you and your student a healthy school year!

Required and recommended vaccines

- Colorado law requires students who attend a public, private, or parochial kindergarten - 12th grade school to be vaccinated against many of the diseases vaccines can prevent, unless an exemption is filed. For more information, visit colorado.gov/cdphe/schoolrequiredvaccines (or cdphe.colorado.gov/schoolrequiredvaccines). Your student must be vaccinated against:
  - diphtheria, tetanus & pertussis (DTaP, DTP, Tdap)
  - polio (IPV)
  - measles, mumps, rubella (MMR)
  - hepatitis B (HepB)
  - varicella (chickenpox)
- Colorado follows recommendations set by the Advisory Committee on Immunization Practices. Students entering kindergarten must receive their final doses of DTaP, IPV, MMR and varicella. Students entering 6th grade must receive one dose of Tdap vaccine, even if they are under 11 years of age. You can view recommended vaccine schedules for children 0 - 6 years of age at cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf and preteens/teens 7 - 18 years of age at cdc.gov/vaccines/schedules/downloads/teen/parent-version-schedule-7-18yrs.pdf.
- Vaccines are recommended for hepatitis A, influenza, meningococcal disease and human papillomavirus, but are not required.

Exclusion from school

- Your student may be excluded from school if your school does not have an up-to-date vaccine record, exemption, or in-process plan for your student on file.
- If someone gets sick with a vaccine-preventable disease or there is an outbreak at your student's school and your student has not received the vaccine for that disease, they may be excluded from school activities. That could mean lost learning time for them and lost work and wages for you. For example, if your student has not received a measles-mumps-rubella (MMR) vaccine, they may be excluded from school for 21 days after someone gets sick with measles.

Have questions?

- You may want to talk to a healthcare provider licensed to give vaccines or your local public health agency about which vaccines your student needs or if you have questions. You can read about the safety and importance of vaccines at SpreadTheVaxFacts.com, ImmunizeForGood.com, and colorado.gov/cdphe/immunization-education (or cdphe.colorado.gov/immunization-education).

Paying for vaccinations

- If you need help finding free or low-cost vaccines and providers who give them, go to COVax4Kids.org, contact your local public health agency, or call the state health department's Family Health Line at 1-303-692-2229 or 1-800-688-7777. You can find your local public health agency at colorado.gov/cdphe/find-your-local-public-health-agency (or cdphe.colorado.gov/find-your-local-public-health-agency).

Vaccination records

- Please take your student's updated vaccine record to school every time they receive a vaccine.
- Need to find your student's vaccine record? It may be available from the Colorado Immunization Information System. Visit COVaxRecords.org for more information.

Exemptions

- If your student cannot get vaccines because of medical reasons, you must submit an official *Immunization Medical Exemption Form* to your school, signed by a health care provider licensed to give vaccines. You only need to submit this form once, unless your student's information or school changes. You can get the form at colorado.gov/vaccineexemption (or cdphe.colorado.gov/vaccineexemption).
- If you choose not to have your student vaccinated according to the current recommended schedule because of personal belief or religious reasons, you must submit a non-medical exemption to your school. Non-medical exemptions must be submitted at ages 2 months, 4 months, 6 months, 12 months and 18 months. The easiest way to file a personal or religious exemption is by using our online or downloadable non-medical exemption form available at colorado.gov/vaccineexemption (or cdphe.colorado.gov/vaccineexemption).

How's your school doing on vaccinations?

- Some parents, especially those with students who have weakened immune systems, may want to know which schools have the highest percent of vaccinated students. Schools must report immunization and exemption numbers (but not student names or birth dates) to the state health department annually. Immunization and exemption rates can be found at COVaxRates.org.

Please share Page 2 of this letter with your student's health care provider as it provides helpful information about vaccines required for school entry, per Colorado law.

Advancing Colorado's health and protecting the places we live, learn, work and play

Dear Colorado health care provider:

Colorado School Entry Immunization Law (25-4-901 et seq, C.R.S) and Colorado Board of Health rule (6 CCR 1009-2) require students who attend a public, private or parochial K - 12 school, licensed child care, preschool, or Head Start program to be vaccinated against many of the diseases vaccines can prevent, or have an exemption on file. For more information, visit, colorado.gov/pacific/cdphe/schoolrequiredvaccines (or cdphe.colorado.gov/schoolrequiredvaccines). Students must be vaccinated against:

- diphtheria, tetanus and pertussis (DTaP, DTP, Tdap)
- polio (IPV)
- measles, mumps, rubella (MMR)
- hepatitis B (HepB)
- haemophilus influenzae type b (Hib)
- pneumococcal (PCV13)
- varicella (chickenpox)

The number, timing and spacing of the required vaccine doses is set by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP). To be considered valid, a dose of vaccine must meet both the **minimum age and minimum intervals** as defined by ACIP. You can view the current ACIP vaccine schedule for persons 0 - 18 years of age at cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf. Vaccines are recommended for rotavirus, hepatitis A, influenza, meningococcal disease and human papillomavirus, but are not required for school attendance.

Colorado schools are required to review immunization records for school entry and can only accept valid doses of vaccine. Your patients may receive notification of noncompliance if a dose of vaccine does not meet the minimum age or minimum interval requirements, per the ACIP schedule. There are three ways a student can meet the compliance requirements established by Colorado law:

1) A student is considered fully immunized if he or she has received all doses of school-required vaccines according to the current ACIP schedule. Note: students are required to receive their final doses of DTaP, IPV, MMR and varicella by kindergarten entry and their Tdap by 6th grade entry, even if the student is under 11 years of age.
2) A student is in the process of becoming up-to-date on required vaccines and has a written plan from the parent/guardian on file with the school.
3) The student's health care provider (medical doctor, doctor of osteopathic medicine, advanced practice nurse or delegated physician assistant) has signed an official *Immunization Medical Exemption Form* because of a condition that precludes the student from receiving vaccine(s), or the student (emancipated or 18 years of age or older) or student's parent/guardian has submitted a signed non-medical exemption (religious or personal belief).

If students do not meet at least one of the compliance criteria, they are not permitted to attend school. If you have questions about the student's school immunization requirement, please communicate with the student's school nurse or school representative.

If you have questions about the ACIP immunization schedule, vaccines marked as invalid in your patient's immunization record, or about Colorado School Entry Immunization Law, please contact us at 303-692-2700 or cdphe.dcdimmunization@state.co.us. If you have questions about the Colorado Immunization Information System (CIIS), please contact us at 303-692-2437 (press 2), 1-888-611-9918 (press 1) or cdphe.ciis@state.co.us.

Other reliable clinical resources include:

- CDC Vaccines & Immunizations - cdc.gov/vaccines/default.htm
- CDC's *Epidemiology & Prevention of Vaccine-Preventable Diseases* - cdc.gov/vaccines/ed/webinar-epv/index.html
- The Immunization Action Coalition: Ask the Experts - immunize.org/askexperts/
- CDC Experts at the National Immunization Program - nipinfo@cdc.gov or 1-800-CDC-Info (1-800-232-4636)