

CERTIFICATE OF IMMUNIZATION



Child's Name (Last name, first name, middle)

Birthdate (mm/dd/yy)

Parent/Guardian Name (Last name, first name, middle)

Phone (please include area code xxx-xxx-xxxx)

Address

City State Zip Code

Religious Exemption

Check here if religious exemption to immunization selected by parent/guardian

Health Examination Documentation (if required)

This child has been examined: MM / DD / YY

Certified by (Signature/Stamp)

Check if needed

Dental Screening

Vision Screening

Unless specifically exempted by law, Tennessee law requires a certificate on file for each child in attendance in any school or child care facility in Tennessee. Detailed instructions for this form and explanation of requirements are in "Instructions for Completion of Immunization Certificates" and the "Official Immunization Schedule" at the Tennessee Department of Health website (<http://health.state.tn.us/CEDS/required.htm>) and on the Tennessee Web Immunization System.

| VACCINE | DATE MM / DD / YY | DATE MM / DD / YY | DATE MM / DD / YY | DATE MM / DD / YY | DATE MM / DD / YY | DATE MM / DD / YY | Total Doses | Diagnosed (YY) | +Serology (YY) | History (YY) | Medical Exemption (X) |
|--|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|-------------|----------------|----------------|--------------|-----------------------|
| Required Vaccines for School or Child Care Attendance | | | | | | | | | | | |
| Hib Child Care Only (<5 years) | | | | | | | | | | | * |
| Pneumococcal (PCV) Child Care Only (<5 years) | | | | | | | | | | | * |
| DTP, DTaP, DT, Td | | | | | | | | | | | * |
| Poliomyelitis | | | | | | | | | | | |
| Hepatitis B <input type="checkbox"/> Check here if 11-15 years 2-dose schedule used | | | | | | | | | | | |
| Hepatitis A Child Care Effective 7/2010 Kindergarten Effective 7/2011 | | | | | | | | | | | |
| Measles | | | | | | | | | | | |
| Mumps | | | | | | | | | | | |
| Rubella | | | | | | | | | | | |
| Varicella | | | | | | | | | | | |
| Tdap Booster 7 th Grade Entry Only | | | | | | | | | | | |
| Recommended Vaccines (Documentation Optional) | | | | | | | | | | | |
| Rotavirus | | | | | | | | | | | * |
| Influenza | | | | | | | | | | | |
| Meningococcal | | | | | | | | | | | |
| HPV | | | | | | | | | | | |

This section must be completed by provider (✓select one*)

- A) Temporary - Expiration Date** MM / DD / YYYY
Expiration one month after date next catch-up immunization is due.
- B) Child Care Up to Date**
Requirements incomplete, but up to date for age Certificate valid until 19 months of age
- C) Child Care / Pre-School / Pre-K Complete***
Fulfills requirements for child care / pre-school <5 years of age.
- D) Complete K-6th Grade***
Fulfills requirements, Kindergarten through 6th grade
- E) Complete 7th grade or higher**
Fulfills requirements, 7th grade or higher.

*If age 4 years and fulfills requirements for Pre-School and Kindergarten, check BOTH Boxes C and D.

Printed or Stamped Name, Address, Phone of Qualified Healthcare Provider or Health Department:

Certified by (Signature/Stamp)

Date of Issue

Vaccine Requirements for Attending Child Care Facilities, Pre-Schools and Schools in Tennessee*

Recommended Schedule of Required Doses for Attendance in Child Care / Pre-School / Pre-K and School For Children Who Started Immunizations Before Age 7 Years**

| Required Vaccines with footnote numbers in [1] | 2 | | 4 | | 6 | | 12-15 | | 16-18 | | 4-6 Yrs.* | | Total Doses Required*** For Checking Complete For School Attendance Box on Immunization Certificate |
|--|-----|-----|-----|-----|-----|-----|-------|-----|-------|-----|-----------|--|---|
| | Age | Age | Age | Age | Age | Age | Age | Age | Age | Age | Age | | |
| [1] Hib HbOC or | 1 | 2 | 3 | 4 | | | | | | | | | N/A for school (See Footnote [1]) |
| [1] Hib PRP-T or | 1 | 2 | 3 | 4 | | | | | | | | | N/A for school (See Footnote [1]) |
| [1] Hib PRP-OMP | 1 | 2 | 3 | 3 | | | | | | | | | N/A for school (See Footnote [1]) |
| [2] PCV | 1 | 2 | 3 | 4 | | | | | | | | | N/A for school (See Footnote [2]) |
| [3] DTP, DTaP, DT | 1 | 2 | 3 | 4 | | | | | | | | | 5, 4 or 3 (See Footnote [3]) |
| [4] Polio | 1 | 2 | 3 | 3 | | | | | | | | | 5, 4 or 3 (See Footnote [4]) |
| [5] Hepatitis B | 1 | 2 | 2 | 3 | | | | | | | | | 3 (See Footnote [5]) |
| [6] Hepatitis A | | | | | | | | | | | | | (See Footnote [6]) |
| [7] MMR | | | | | | | | | | | | | 2 (See Footnote [7]) |
| [8] Varicella | | | | | | | | | | | | | 2 (See Footnote [8]) |
| [9] Tdap | | | | | | | | | | | | | 2 (See Footnote [9]) |

*These requirements were established in accordance with the current Recommended Childhood and Catch-Up Immunization Schedules, United States. Tennessee requirements for Kindergarten (5 years) include doses indicated for 4-6 years.

**For children starting immunizations at age 7 years or older, refer to the catch up schedule available at the Department of Health website or the AClP catch-up schedule for that age available at www.cdc.gov/vaccines.

***Children who are behind schedule may attend while in the process of completing the requirements with minimum intervals as indicated below.

Minimum Ages For Initial Immunization And Minimum Intervals Between Doses

| Vaccine | Minimum Age For First Dose | Minimum interval from dose 1 to 2 | Minimum interval from dose 2 to 3 | Minimum interval from dose 3 to 4 | Minimum interval from dose 4 to 6 |
|--|----------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| [1] Hib (Primary Series) HbOC & PRP-T | 6 weeks | 1 month | 1 month | See Footnote [1] | N/A |
| [2] PCV | 6 weeks | 1 month | 1 month | See Footnote [2] | N/A |
| [3] DTP/DTaP (DT) | 6 weeks | 1 month | 1 month | See Footnote [3] | N/A |
| [4] Polio | 6 weeks | 1 month | 1 month | See Footnote [4] | N/A |
| [5] Hepatitis B | 12 months | 1 month | 1 month | See Footnote [5] | N/A |
| [6] Hepatitis A | 12 months | 1 month | 1 month | N/A | N/A |
| [7] MMR | 12 months | 12 months | 12 months | N/A | N/A |
| [8] Varicella | 12 months | 3 months | 3 months | N/A | N/A |
| [9] Tdap | See Footnote [9] | | | | |

With respect to these intervals, 1 month is a minimum of 4 weeks or 28 days.

Do not restart any series, no matter how long since the previous dose. Doses given 5-4 days before the minimum age or the minimum interval may be counted as valid. Two different live vaccines must be given on the same day or spaced at least 28 days apart.

Footnotes

- The number of doses of Hib depends on age at 1st dose and brand of vaccine given. The last dose in this series necessary to meet requirements, whether 3rd or 4th, should be given at least 2 months after the previous dose and not before 12 months of age. One dose is sufficient to meet requirements if it is given at age 15 months or later. Hib is not required for kindergarten or higher grades and is not indicated for children who have reached the 5th birthday. If given on schedule, PRP-T and HbOC have a 3-dose primary series and a booster after age 12 months. PRP-OMP has a 2-dose primary schedule and a booster after 12 months. Providers are responsible for verifying that the child meets the appropriate schedule for the brand used.
- The number of doses in the PCV series depends on age at 1st dose. The last dose in the series should be given at least 2 months after the previous dose and not before 12 months of age. One dose of PCV is required for all children aged 24-59 months in child care with any incomplete schedule.
- The minimum interval between the 4th and 5th doses is 6 months. It may be given as early as 12 months, but typically is given at age 15-18 months. One dose of DTP/DTaP/DT must be on or after the 4th birthday. If the 4th dose was on or after the 4th birthday, the 5th dose is not needed. The 4th dose should be administered a minimum of 6 months after the 3rd dose. However, the 4th dose does not need to be repeated if administered ≥ 4 months after dose 3. Total doses of diphtheria and tetanus toxoids should not exceed 6 before the 7th birthday.
- The final dose of the polio vaccine series must be given on or after the 4th birthday and at least 6 months after the previous dose. If 4 doses are administered before the 4th birthday, a 5th dose should be given at 4-6 years. If the 3rd dose of an all IPV or all OPV series is given on or after the 4th birthday and at least 6 months after the 2nd dose, a 4th dose is not needed.
- The 3rd dose of Hepatitis B vaccine should be given a minimum of 4 months after the 1st dose and 2 months after the 2nd dose and not before 24 weeks of age.
- One dose of Hepatitis A vaccine is required for all children in child care aged 18 months or greater. The recommended schedule is for two doses to be given, 6 months apart, between 12 and 24 months of age. Effective July 2011, proof of a total of two doses is required by Kindergarten entry.
- The MMR requirement is 2 doses of measles vaccine, 2 doses of mumps vaccine and 2 doses of rubella vaccine. The vaccines may be given as MMR or MMRV (combined antigens) or as single antigens.
- The varicella requirement is for 2 doses of varicella-containing vaccine or history of disease for all students entering K or 7th grade, and new entrants into a Tennessee school in any other grade. These may be administered as single dose varicella or in combination as MMRV.
- Tdap is required for 7th grade entry. Tdap is NOT required if a Td booster dose is recorded as given less than 5 years before 7th grade entry (on the appropriate DTaP / DT / Td line of the certificate).

FIRST ASSEMBLY CHRISTIAN SCHOOL

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Authorization for Administration of Medications

Academic Year _____

Name of Student: _____ Grade: _____ Birth Date: _____ Date: _____

Medication Allergies: _____

Diagnosis for which medication is given: _____
(i.e. Behavioral, Seizure, Asthma, Diabetes, etc.)

Medication Name: _____ Dosage: _____ Route: _____

Form (pill, inhaler, liquid) _____ How often to be given: _____

Relevant Side Effects: _____

Discontinuation Date: _____

(All medications will be discontinued at the end of the academic school year unless otherwise noted.)

Authorization by Parent/Guardian:

I hereby request that the school nurse/assistant administer the above medication. I understand that I **must** supply the school with the original prescription container (label intact) or the non-prescription container in compliance with the FACS Medication Policy.

Is the student physically and mentally able to self-administer the medication with assistance? YES ___ NO ___

The undersigned agree not to file or make any claim against anyone for negligence in connection with the administration or non-administration of any medications and further agree to save such individuals and hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines. I have read and understand the Guidelines for Administration of Medication and will abide by them.

Physician's Signature (prescription drugs only) _____ Dates: _____

Parent/Guardian Signature: _____ Dates: _____

Medication Returned to Parent/Guardian:

Date _____ Signature _____