



# Is Your Child Ready for Child Care or School?

## Learn about required vaccinations in New York City

2019-2020 School Year



All students ages 2 months to 18 years in New York City must get the following vaccinations to go to child care or school. Review your child's vaccine needs based on their grade level this school year.

VACCINATIONS	REQUIRED			
	Pre-Kindergarten (Child Care, Head Start, Nursery, 3K or Pre-k)	Kindergarten – Grade 5	Grades 6 – 11	Grade 12
Diphtheria, tetanus and pertussis (DTaP)	4 doses	5 doses or 4 doses ONLY if the fourth dose was received at age 4 years or older or 3 doses ONLY if the child is 7 years or older and the series was started at age 1 year or older	3 doses	
Tetanus, diphtheria and pertussis booster (Tdap)			1 dose (on or after age 11 years)	
Polio (IPV/OPV)	3 doses	4 doses or 3 doses if the third dose was received at age 4 years or older	4 doses or 3 doses ONLY if the third dose was received at age 4 years or older	3 doses
Measles, mumps and rubella (MMR)	1 dose	2 doses		
Hepatitis B	3 doses	3 doses	3 doses or 2 doses of adult Hepatitis B vaccine (Recombivax HB) if the doses were received at least 4 months apart between the ages of 11 and 15 years	
Varicella (chickenpox)	1 dose	2 doses		1 dose
Meningococcal conjugate (MenACWY)			Grades 7, 8, 9 and 10: 1 dose	2 doses or 1 dose ONLY if the first dose was received at age 16 years or older
Haemophilus influenzae type B conjugate (Hib)	1 to 4 doses Depends on child's age and doses previously received			
Pneumococcal conjugate (PCV)	1 to 4 doses Depends on child's age and doses previously received			
Influenza	1 dose			

The number of vaccine doses your child needs may vary based on age and previous vaccine doses received. Your child may need additional vaccines or vaccine doses if they have certain health conditions. Talk to your doctor if you have questions. For more information, call 311 or visit [nyc.gov/health](http://nyc.gov/health) and search for **student vaccines**.

# New York State Recommended Childhood and Adolescent Immunization Schedule

A check ✓ means that this is the earliest and best time for your child to be immunized. If your child misses the “best time” for vaccination, he or she should still be immunized as quickly as possible. Ask your doctor about getting your child caught up.

Vaccine against:	Birth	2 months	4 months	6 months	12 months	15 months	18-23 months	4-6 years	11-12 years	16 years	
Hepatitis B	✓	✓ 1-2 mo.		✓ 6-18 mo.							
Rotavirus		✓	✓	✓ <sup>1</sup>							
Diphtheria, Tetanus, Pertussis (DTaP)		✓	✓	✓		✓ 15-18 mo.		✓			
Tetanus, Diphtheria, Pertussis (Tdap) <sup>2</sup>									✓ <sup>2</sup>		
<i>Haemophilus influenzae</i> type b (Hib)		✓	✓	✓ <sup>1</sup>	✓ 12-15 mo.						
Pneumococcal Disease (PCV) <sup>3</sup>		✓	✓	✓	✓ 12-15 mo.		Ask your doctor if your child 2 years old or older should get vaccinated with PPSV23. <sup>3</sup>				
Polio (IPV)		✓	✓	✓ 6-18 mo.				✓			
Influenza	Recommended yearly for all children aged 6 months and older. Ask your doctor if your child should receive one or two doses.										
Measles, Mumps, Rubella (MMR) <sup>4</sup>				See footnote 4	✓ 12-15 mo.			✓			
Varicella (Chickenpox)					✓ 12-15 mo.			✓			
Hepatitis A					✓		✓				
Human Papillomavirus (HPV) <sup>5</sup>									✓ <sup>5</sup>		
Meningococcal Disease <sup>6</sup>		Ask your doctor if your child 2 months old or older should get vaccinated against meningococcal disease.							✓		✓

<sup>1</sup> For some types of Hib and Rotavirus vaccine, the 6-month dose is not needed.

<sup>2</sup> Tdap: Children 7-10 years old who are not fully immunized against pertussis should receive a single dose of Tdap.

<sup>3</sup> PCV = Pneumococcal Conjugate Vaccine; PPSV23 = Pneumococcal Polysaccharide Vaccine

<sup>4</sup> MMR: Children 6-11 months old who are traveling outside the U.S. should receive one dose of MMR before departure.

<sup>5</sup> The HPV vaccine includes two shots given 6 months apart. It is recommended for both boys and girls. Teens who start the series after age 15, and some children with special medical conditions, may need three doses.

<sup>6</sup> There are two vaccines that protect against meningococcal disease. Some children with special medical conditions may need both MCV4 and MenB.

Attach student photo here

# ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2019-2020

Please return to school nurse. Forms submitted after May 31, 2019 may delay processing for new school year

Student Last Name	First Name	Middle	Date of birth ____/____/____ MM DD YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female
OSIS Number _____	Weight _____ kg			
School (include ATSDBN/name, number, address and borough)			DOE District	Grade
			Class	

## HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergy	Specify Allergy	Specify Allergy
<input type="checkbox"/> Allergy to	<input type="checkbox"/> Allergy to	<input type="checkbox"/> Allergy to
History of asthma? <input type="checkbox"/> Yes (If yes, student has an increased risk for a severe reaction) <input type="checkbox"/> No	Does this student have the ability to:	
History of anaphylaxis? <input type="checkbox"/> Yes Date ____/____/____ <input type="checkbox"/> No	Self-Manage (See 'Student Skill Level' below)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, system affected <input type="checkbox"/> Respiratory <input type="checkbox"/> Skin <input type="checkbox"/> GI <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Neurologic	Recognize signs of allergic reactions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment	Date ____/____/____	Recognize/avoid allergens independently <input type="checkbox"/> Yes <input type="checkbox"/> No

### Select In School Medications

#### 1. SEVERE REACTION

##### A. Immediately administer epinephrine ordered below, then call 911.

- 0.15 mg
- 0.3 mg

Give intramuscularly in the anterolateral thigh for **any** of the following symptoms (*retractable devices preferred*):

- Shortness of breath, wheezing, or coughing
- Pale or bluish skin color
- Weak pulse
- Many hives or redness over body
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Lip or tongue swelling that bothers breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Feeling of doom, confusion, altered consciousness or agitation

Other: \_\_\_\_\_

If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): \_\_\_\_\_  
Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

##### B. If no improvement, or if symptoms recur, repeat in \_\_\_\_\_ minutes for maximum of \_\_\_\_\_ times (not to exceed a total of 3 doses)

##### C. Give antihistamine after epinephrine administration (*order antihistamine below*)

#### Student Skill Level (select the most appropriate option)

- Nurse-Dependent Student: nurse/nurse-trained staff must administer
- Supervised Student: student self-administers, under adult supervision

Independent Student: student is self-carry/self-administer

*I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.*

Practitioner's Initials

#### 2. MILD REACTION

##### A. Give antihistamine: Name: \_\_\_\_\_ Preparation/Concentration: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Frequency:  Q4 hours or  Q6 hours as needed for **any** of the following symptoms:

- Itchy nose, sneezing, itchy mouth
- A few hives or mildly itchy skin
- Mild stomach nausea or discomfort
- Other: \_\_\_\_\_

##### B. If symptoms of severe allergy/anaphylaxis develop, or if more than one symptom from each system is present, use epinephrine and call 911.

#### Student Skill Level (select the most appropriate option)

- Nurse Dependent Student: nurse must administer
- Supervised Student: student self-administers, under adult supervision

Independent Student: student is self-carry/self-administer

*I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.*

Practitioner's Initials

#### 3. OTHER MEDICATION

##### • Give Name: \_\_\_\_\_ Preparation/Concentration: \_\_\_\_\_ Dose: \_\_\_\_\_

Route: \_\_\_\_\_ Frequency: Q \_\_\_\_\_  minutes  hours as needed

Specify signs, symptoms, or situations: \_\_\_\_\_

If no improvement, indicate instructions: \_\_\_\_\_

Conditions under which medication should not be given: \_\_\_\_\_

#### Student Skill Level (select the most appropriate option)

- Nurse-Dependent Student: nurse must administer
- Supervised Student: student self-administers, under adult supervision

Independent Student: student is self-carry/self-administer

*I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.*

Practitioner's Initials

### Home Medications (include over-the counter)

Health Care Practitioner Name LAST (Please print and circle one: MD, DO, NP, PA)	FIRST	Signature	Date ____/____/____
Address		Tel. (____) ____-____	Fax. (____) ____-____
NYS License # (Required)	NPI #		

# ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2019–2020  
 Please return to school nurse. Forms submitted after May 31<sup>st</sup> may delay processing for new school year  
**PARENTS/GUARDIANS FILL BELOW**

## BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
  - I must give the school nurse my child's medicine and equipment. I will try to give the school epinephrine pens with retractable needles.
  - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
    - Prescription medicine must have the original pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
  - I certify/confirm that I have checked with my child's health care practitioner and I consent to the OSH giving my child stock medication in the event my child's asthma or epinephrine medicines are not available.
  - I must **immediately** tell the school nurse about any change in my child's medicine or the health care practitioner's instructions.
  - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
  - By signing this medication administration form (MAF), I authorize the Office of School Health (OSH) to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
  - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier).
  - This form represents my consent and request for the allergy services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
  - For the purposes of providing care or treatment for my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

## SELF-ADMINISTRATION OF MEDICATION (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.
- I consent to the school nurse or trained school staff giving my child medicine if my child is temporarily unable to carry and give him or herself medicine.

**NOTE: If you decide to use stock, you must send your child's epinephrine, asthma inhaler and other approved self-administered medications on a school trip day and/or after school programs in order that he/she has it available. Stock medications are only for use by OSH staff in school only.**

Student Last Name	First Name	MI	Date of birth ___/___/_____	School	
School ATSDBN/Name			Borough	District	
Parent/Guardian's Name (Print)			<b>SIGN HERE</b> →	Parent/Guardian's Signature	
Parent/Guardian's Email				Date Signed ___/___/_____	
Parent/Guardian's Address			Parent/Guardian's Address		
Telephone Numbers: Daytime (____) _____ - _____ Home (____) _____ - _____ Cell Phone (____) _____ - _____					
Alternate Emergency Contact's Name		Relationship to Student	Contact Telephone Number (____) _____ - _____		

## For Office of School Health (OSH) Use Only

OSIS Number: \_\_\_\_\_

Received by: Name \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_ Reviewed by: Name \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_

504     IEP     Other    Referred to School 504 Coordinator:  Yes     No

Services provided by:  Nurse/NP     OSH Public Health Advisor (For supervised students only)     School Based Health Center

Signature and Title (RN OR SMD): \_\_\_\_\_ Date School Notified & Form Sent to DOE Liaison \_\_\_ / \_\_\_ / \_\_\_\_\_

Revisions as per OSH contact with prescribing health care practitioner  Modified     Not Modified