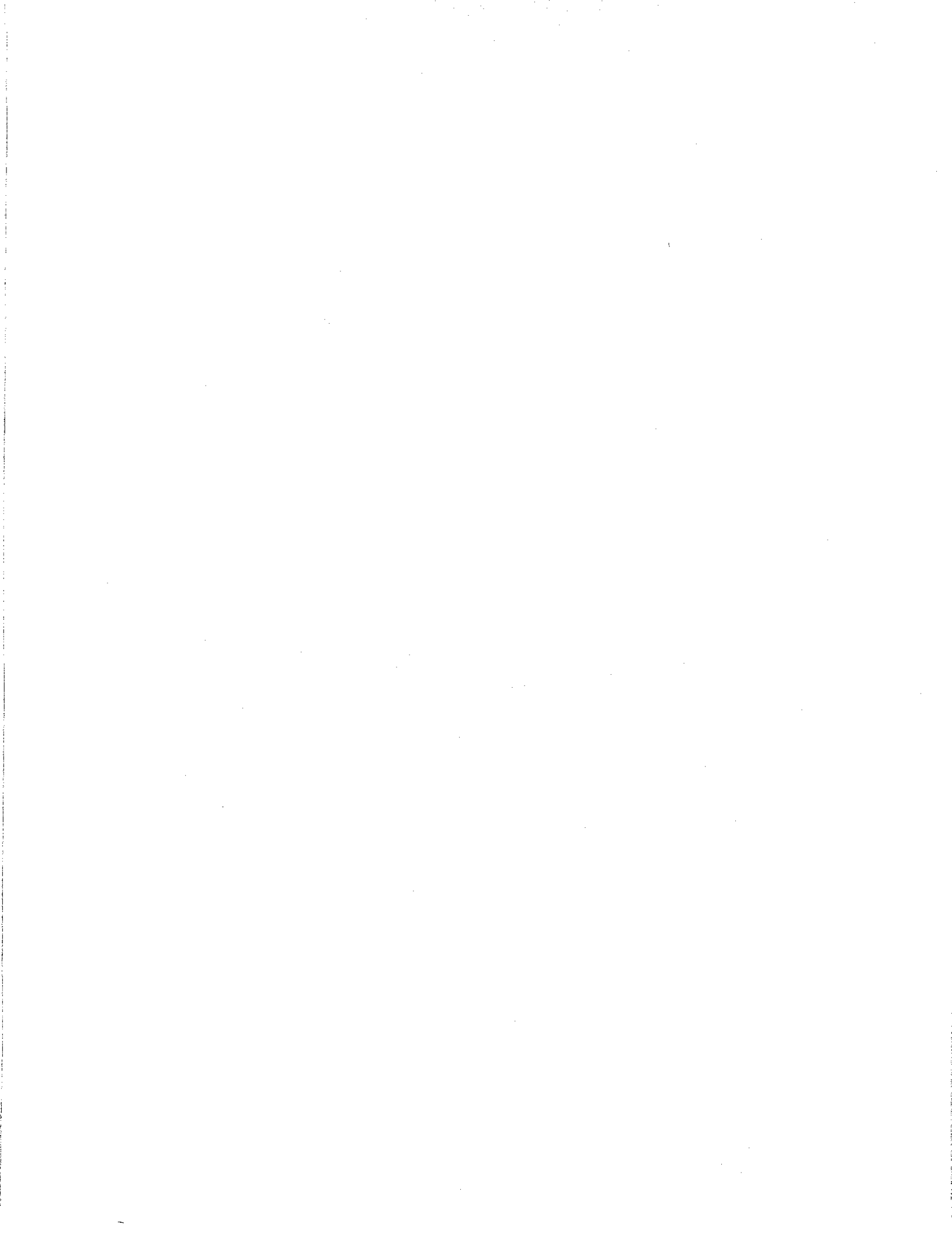


Section E

IMMUNIZATION/ PHYSICAL EXAMINATION REQUIREMENTS

- Immunization Materials Request Form
- California School Immunization Law for
 - *Child Care*
 - *Grades K-12*
- California School Immunization Record: *English/Spanish*
- SFUSD Policy-Health Exam/Immunization/Tuberculosis
- Immunization Requirements for Homeless Children and Youth
WAD
- Health Form/Physical Exam Form Instructions
- San Francisco School Health Form
- Preparticipation Physical Evaluation Form
- Exemptions Information Sheet: *English/Spanish*
- San Francisco Waiver for Immunization/Health Exam
- Recommended Childhood Immunization Schedule
- New 7th Grade Immunization Law
- 6th Grade Requirements: Letters to Parents (*English/ Spanish*)
- Protect Your Baby From Whooping Cough Flyer:
English/Spanish
- Varicella Immunization Requirement WAD
- Notice of Incomplete Health Requirements:
English/Spanish/Chinese/Russian/Vietnamese/Tagalog
- Notice of Exclusion from School:
English/Spanish/Chinese/Russian/Vietnamese/Tagalog



IMMUNIZATION MATERIALS REQUEST FORM

Please read and follow the directions carefully to ensure the quality and accuracy of your order.
For specific questions or more information, please leave a message at (415) 554-2794.

1) Your Contact Information

Date ____/____/____

Agency Name _____

Contact Name _____ Phone # (____) _____

Shipping Address _____ Fax # (____) _____

City _____ State _____ Zip Code _____

2) Delivery Times

For most orders, please allow a minimum of **two weeks** for delivery. For urgent orders, **next day pickup is available**.

3) Material Listing

Materials are available **free of charge** and listed according to category. Please indicate the quantity of items (QTY) and circle the language code (E= English, S= Spanish, C= Chinese) preferred in the columns provided.

VACCINE INFORMATION STATEMENTS

Federal Law mandates that **Vaccine Information Statements (VISs)** be provided every time an immunization is administered. VISs are available in multiple languages. For master copies, call **1-800-PIK-VIPS** or **415-554-2794**. Individuals with internet access can also print current Vaccine Information Statements (in multiple languages) by visiting www.immunize.org/vis/index.htm

BROCHURES			
"Babies Need Their Baby Shots On Time"		Multi-lingual	
"6 th Grade Hep B Vaccine" Brochure		E	
Be There For Your Child during shots Guide		E	
A Parent's Guide to Vaccine Preventable Diseases		E S	
What If You Don't Immunize Your Child?		E	

SCHOOL/CHILDCARE MATERIALS

- For other school forms, call the SFUSD - School Health Programs Dept. at **242-2615**.

STICKERS			
Parent of the Year		E	
"GOT IZ'D"		E	
"I'm Loved" Heart		E S	
"I'm Loved" Bear		E S	
Next Immunization is Due:		E	
"Remember: Bring Child's Record"		E	
Schedule for Child's Immunizations		E/S	

Name of Item	LANG.	QTY.
Blue School Immunization Cards	E	
Pink Windows for reading blue cards	E	max/ 5
Purple Windows for reading blue cards	E	max/ 5
California IZ Handbook	E	

POSTERS			
Baby Blocks Immunization Timing Chart (Horizontal)		E S	
Baby Blocks Immunization Timing Chart (Vertical)		E S C	
Flu Shot/Diabetes Poster		E S	
Anatomical Sites for Immunization Poster		E	
Summary of Pediatric IZ Recommendation		E	

CLINIC/OUTREACH MATERIALS

Name of Item	LANG.	QTY.
Yellow Immunization Cards	E/S E/C	
Plastic Sleeves for yellow cards		
Bear Reminder Post Cards (pink)	E	
Bilingual General Reminder Post Cards	E S	
6 th Grade Hepatitis Reminder Post Cards	E	
Vaccine Storage & Handling Reference Chart	E	
Handle with Care Vaccine Storage Flyer	E	
Adult IZ Recommendation Guide (2000)	E	
Immunization Record and History Chart	E	

SF IMMUNIZATION COALITION MATERIALS

For specific questions or more information, please call **SFIC** at **415-835-3115**

Name of Item	LANG.	QTY.
Afrocentric Poster (11 x 17)	E	
Afrocentric Magnet - removable photo frame	E	
Trilingual Bookmark -English/Spanish/Chinese	E/S/C	
Multi-ethnic Baby "Remember" Poster -english (11x17) -spanish (11 x 28)	E S	
Baby's IZ Reminder Magnet (business card size)	E S C	

Fax this completed form to:
SFDPH, Immunization Program 554-2579



CALIFORNIA IMMUNIZATION REQUIREMENTS FOR

Child Care



REFERENCE Health and Safety Code, Division 105, Part 2, Chapter 1, Sections 120325-120380; California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 8, Sections 6000-6075

INSTRUCTIONS To attend child care, children must have immunizations outlined below by age. Parents must present their child's Immunization Record as proof of immunization. Copy the full date of each shot onto the blue California School Immunization Record card and then determine if the child is up-to-date. Blue cards are available free from the Immunization Coordinator at your local health department. As the child care provider, it is your responsibility to follow up regularly until all shots are finished.

IMMUNIZATIONS (SHOTS) REQUIRED TO ATTEND CHILD CARE, BY AGE



Age When Enrolling	Immunizations (Shots) Required
2-3 months.....	1 each of Polio, DTaP, Hib, Hep B
4-5 months.....	2 each of Polio, DTaP, Hib, Hep B
6-14 months.....	3 DTaP 2 each of Polio, Hib, Hep B
15-17 months.....	3 each of Polio, DTaP 2 Hep B 1 MMR, on or after the first birthday ¹ 1 Hib on or after the first birthday ¹
18 months-5 years.....	3 Polio 4 DTaP 3 Hep B 1 MMR, on or after the first birthday ¹ 1 Hib on or after the first birthday ^{1,3} 1 Varicella (chickenpox) ²

Vaccines

DTaP: Diphtheria, tetanus, and pertussis combined vaccine. Record may show DT or DTP.

Hib: *Haemophilus influenzae* type b vaccine; required only for children up to age 4 years, 6 months.

MMR: Measles, mumps, and rubella combined vaccine.

Hep B: Hepatitis B vaccine.

Varicella: Chickenpox vaccine.

You may admit a child who is lacking one or more required vaccine doses if the dose(s) is not currently due **on the condition** that they receive the remaining dose(s) when due, according to the schedule above. You will need to review records to make sure this occurs. If the maximum time interval between doses has passed, the child cannot be admitted until the next immunization is obtained.

¹ Receipt of the dose up to (and including) 4 days before the birthday will satisfy the child care entry immunization requirement.

² If a child had chickenpox disease and this is indicated on the Immunization Record by the child's physician, they meet the requirement. Write "disease" in the chickenpox date box on the blue card.

³ Required only for children who have not reached the age of 4 years 6 months.

WHEN NEXT SHOTS ARE DUE

Polio #2	6-10 weeks after 1st dose
Polio #3	6 weeks-12 months after 2nd dose
DTP or DTaP #2, #3	4-8 weeks after previous dose
Hib #2	2-3 months after 1st dose
DTP or DTaP #4	6-12 months after 3rd dose
Hep B #2	1-2 months after 1st dose
Hep B #3	Under age 18 months: 2-12 months after 2nd dose and at least 4 months after 1st dose Age 18 months and older: 2-6 months after 2nd dose and at least 4 months after 1st dose

EXEMPTIONS

The law allows (a) parents/guardians to choose exemptions from immunization requirements based on their personal beliefs, and (b) physicians of children to choose medical exemptions from them. The law does not allow parents/guardians to choose an exemption simply because the "shot" record is lost or incomplete and it is too much trouble to get to a physician or clinic to correct the problem. The back of the blue California School Immunization Record has instructions and an affidavit to be signed by parents who want a personal beliefs exemption. An up-to-date list of children with exemptions should be maintained separately by the child care staff so that these children can be quickly identified and excluded from attendance if an outbreak occurs.

Cuidado infantil



REFERENCIA Health and Safety Code, Division 105, Part 2, Chapter 1, Sections 120325-120380; California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 8, Sections 6000-6075

INSTRUCCIONES Para asistir al cuidado infantil, los niños deben estar vacunados como notado abajo por la edad del niño. Los padres deben presentar el Comprobante de Inmunización de su hijo antes de inscribirlo. Anote la fecha completa (día/mes/año) de cada vacuna en el Comprobante de Vacunación Escolar de California (la tarjeta azul). De esa manera, puede determinar si el niño está al día. Las tarjetas azules se pueden solicitar sin costo alguno al Coordinador de Vacunación de su departamento de salud local. Como proveedor de cuidado infantil, es su responsabilidad de dar seguimiento hasta que los niños hayan recibido todas sus vacunas.

VACUNAS REQUERIDAS PARA ASISTIR A LA GUARDERIA, POR EDAD	Edad al inscribirse	Vacunas requeridas
	2 a 3 meses	1 de cada una de las siguientes: poliomielitis, DTaP, Hib, Hep B
	4 a 5 meses	2 de cada una de las siguientes: poliomielitis, DTaP, Hib, Hep B
	6 a 14 meses	3 DTaP
	15 a 17 meses	2 de cada una de las siguientes: poliomielitis, Hib, Hep B 3 de cada una de las siguientes: poliomielitis, DTaP 2 Hep B 1 MMR en la fecha en que cumple un año de edad, o después ¹ 1 Hib aplicada en la fecha en que cumple un año de edad, o después ¹
	18 meses a 5 años	3 poliomielitis 4 DTaP 3 Hep B 1 MMR en la fecha en que cumple un año de edad, o después ¹ 1 Hib aplicada en la fecha en que cumple un año de edad, o después ^{1,3} 1 varicela ²



DTaP: Vacuna combinada contra la difteria, el tétano y la tos ferina. El comprobante puede mostrar DT o DTP.
 Hib: Vacuna contra la *Haemophilus influenzae* tipo b; requerida solo para los niños de hasta 4 años y 6 meses de edad.
 MMR: Vacuna combinada contra el sarampión, las paperas y la rubéola.
 Hep B: Hepatitis B.
 Varicela: Vacuna contra la varicela.

Puede admitir a un niño al que le falte(n) una o más dosis requerida(s) de la(s) vacuna(s), pero que el intervalo máximo entre las dosis no haya transcurrido, con la condición de que reciba la(s) dosis restantes cuando se las tenga que aplicar, de acuerdo con el esquema anterior. Usted tendrá que ver los datos para verificar que el niño haya sido vacunado. Si transcurrió el intervalo de tiempo máximo entre las dosis, no se puede admitir al niño hasta que reciba la próxima vacuna.

¹ Recibo de la dosis hasta 4 días antes del cumpleaños satisface el requerimiento del registro de cuidado infantil.

² Si un niño tuvo varicela y el médico lo documentó en su registro de vacunación, el requerimiento ha sido cumplido. Escriba "enfermedad" en el área de varicela en la tarjeta azul.

³ Se requiere solamente para todos los niños que no hayan cumplido los 4 años y 6 meses.

CUANDO DEBE RECIBIR LAS PROXIMAS VACUNAS	
Poliomielitis No. 2	entre 6 y 10 semanas después de la primera dosis
Poliomielitis No. 3	entre 6 semanas y 12 meses después de la segunda dosis
DTP o DTaP No. 2, No. 3	entre 4 y 8 semanas después de la dosis anterior
Hib No. 2	entre 2 y 3 meses después de la primera dosis
DTP o DTaP No. 4	entre 6 y 12 meses después de la tercera dosis
Hep B No. 2	entre 1 y 2 meses después de la primera dosis
Hep B No. 3	Para los niños menores de 18 meses de edad: entre 2 y 12 meses después de la segunda dosis y al menos 4 meses después de la primera dosis Para los niños mayores de 18 meses de edad: entre 2 y 6 meses después de la segunda dosis y al menos 4 meses después de la primera dosis

EXENCIONES La ley permite (a) que los padres o tutores opten por eximir a sus hijos de los requisitos de vacunación a causa de sus creencias personales y (b) que los médicos de los niños opten por eximirlos de la vacunación por motivos médicos. La ley no permite que los padres o tutores opten por una exención por el mero hecho de que hayan perdido el comprobante de la vacunación, o porque el comprobante no este completo, y les resulte demasiado incómodo ir a un médico o a una clínica para corregir el problema. El reverso de la tarjeta azul de Comprobante de Vacunación Escolar de California contiene instrucciones y una declaración jurada que debe ser firmada por los padres que deseen una exención por sus creencias personales. El personal de la guardería debe mantener una lista actualizada de los niños con exenciones, a fin de que esos niños puedan ser identificados rápidamente y excluidos de la asistencia si hay un brote.

GUIDE TO IMMUNIZATIONS REQUIRED FOR SCHOOL ENTRY

Grades K-12



REFERENCE Health and Safety Code, Division 105, Part 2, Chapter 1, Sections 120325-120380; California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 8, Sections 6000-6075

INSTRUCTIONS Post this guide on a wall or desktop as a quick reference to help you determine whether children seeking admission to your school meet California's school immunization requirements. If you have any questions, call the Immunization Coordinator at your local health department.

IMMUNIZATION REQUIREMENTS To enter or transfer into public and private elementary and secondary schools (grades kindergarten through 12), children under age 18 years must have immunizations as outlined below.

VACCINE

REQUIRED DOSES

Polio

4 doses at any age, but... 3 doses meet requirement for ages 4-6 years if at least one was given on or after the 4th birthday¹; 3 doses meet requirement for ages 7-17 years if at least one was given on or after the 2nd birthday.¹

Diphtheria, Tetanus, and Pertussis

Age 6 years and under (Pertussis is required)

DTP, DTaP or any combination of DTP or DTaP with DT (diphtheria and tetanus)

Age 7 years and older (Pertussis is not required)

Td, DT, or DTP, DTaP or any combination of these

5 doses at any age, but... 4 doses meet requirements for ages 4-6 years if at least one was on or after the 4th birthday.¹

4 doses at any age, but... 3 doses meet requirement for ages 7-17 years if at least one was on or after the 2nd birthday.¹ If last dose was given before the 2nd birthday, one more (Td) dose is required.

7th grade

Td booster

1 dose not required but recommended if more than 5 years have passed since last DTP, DTaP, DT, or Td dose.

Measles, Mumps, Rubella (MMR)

Kindergarten

7th grade

Grades 1-6 and 8-12

2 doses² both on or after 1st birthday.¹

2 doses² both on or after 1st birthday.¹

1 dose must be on or after 1st birthday.¹

Hepatitis B

Kindergarten

7th grade

3 doses at any age

3 doses³ at any age

Varicella

Kindergarten

Out-of-state entrants (grades 1-12)

1 dose⁴

1 dose for children under 13 years; 2 doses are needed if immunized on or after 13th birthday.⁴

- ¹ Receipt of the dose up to (and including) 4 days before the birthday will satisfy the school entry immunization requirement.
- ² Two doses of measles-containing vaccine required. One dose of mumps and rubella-containing vaccine required; mumps vaccine is not required for children 7 years of age and older.
- ³ Two doses of the 2-dose hepatitis B vaccine formulation along with provider documentation that the 2-dose hepatitis B vaccine formulation was used for both doses and both doses were received at age 11-15 years will also fulfill this requirement.
- ⁴ Physician-documented varicella (chickenpox) disease history or immunity meets the varicella requirement.

EXEMPTIONS

The law allows (a) parents/guardians to choose an exemption from immunization requirements based on their personal beliefs, and (b) physicians of children to elect medical exemptions. The law does not allow parents/guardians to elect an exemption simply because of inconvenience (a record is lost or incomplete and it is too much trouble to go to a physician or clinic to correct the problem). See the back of the blue California School Immunization Record (PM 286) for instructions and the affidavit to be signed by parents/guardians electing the personal beliefs exemption. For children with medical exemptions, the physician's written statement should be stapled to the CSIR. Schools should maintain an up-to-date list of pupils with exemptions, so they can be excluded quickly if an outbreak occurs.

Continued on the next page...

PUPILS NOT MEETING REQUIREMENTS

Refer pupils who do not meet these State requirements to their physician or local health department. Give families a written notice indicating which doses are lacking.

DOCUMENTATION All children must present an immunization record.



What is it? It is a written immunization record, either a personal record with entries made by a physician or clinic, or a school immunization record—the blue California School Immunization Record (PM 286) from a former school or another state's school record. It must include at least the month and year each dose was received; for measles, rubella, and/or mumps vaccine given in the month of the first birthday, month, day, and year are required. A record with check marks instead of dates or saying only "up-to-date," "all requirements met," or "series complete" is inadequate. Also, parents cannot simply fill out a California School Immunization Record from memory but must present a written immunization record. Further, the record must show that all due vaccine doses have been received.

Who must present it? All children under age 18 years entering school or transferring between school campuses. Kindergarten entrants and entrants from outside the U.S. must present a personal immunization record. (Kindergarten entrants can present a California School Immunization Record from a child care center they previously attended, but this record usually will not include the final "booster" polio and DTP or DTaP vaccine doses or the second measles-containing vaccine dose.) Children transferring from other schools in California or other states must present either a personal immunization record or a state school immunization record. As of July 1, 1999, students entering 7th grade must present a personal immunization record so that the 7th grade requirement immunization dates can be added to the student's school immunization record.

When must it be presented? Kindergarten entrants, 7th grade entrants, and entrants from outside the U.S. must present the record at or before entry; no "grace period" of attendance is allowed for these pupils if they do not have a record. Children transferring from other schools in California or other states, or entering at other grade levels may be given up to 30 school days of attendance while waiting for their records to arrive from the previous school.

What do schools do with it? School staff must transcribe the immunization dates onto the California School Immunization Record (CSIR or blue card; PM 286), which is available from local health departments. School staff should then review the blue card to determine whether all immunization requirements have been met. The blue card is part of the child's Mandatory Permanent Pupil Record and must be transferred to the child's new school when he/she leaves your school. Although some vaccine doses are not required, please record dates of all doses from the child's personal immunization records on to PM 286. This information will be valuable should outbreaks of these diseases occur in your school.

CONDITIONAL ADMISSIONS

Children who lack one or more required vaccine doses that are not currently due may be admitted on condition that they receive the remaining doses when due, according to the schedule below. If the maximum time interval between doses has passed, the child must be excluded until the next immunization is obtained.

VACCINE	TIME INTERVALS BETWEEN DOSES
Polio	2nd dose: 6–10 weeks after 1st dose 3rd dose: 6 weeks to 12 months after 2nd dose
DTP, DTaP, DT, Td Under 7 years (DTP, DTaP, DT)	2nd dose: 4–8 weeks after 1st dose 3rd dose: 4–8 weeks after 2nd dose 4th dose: 6–12 months after 3rd dose
Age 7 years and older (Td)*	2nd dose: 4–8 weeks after 1st dose 3rd dose: 6–12 months after 2nd dose
MMR	2nd dose: 1–3 months after 1st dose
Hepatitis B for 3-dose formulation	2nd dose: 1–2 months after 1st dose 3rd dose: 2–6 months after 2nd dose and at least 4 months after 1st dose
for 2-dose formulation (7th grade entry for child 11 through 15 years old)	2nd dose: 4–8 months after 1st dose
Varicella (unimmunized out-of-state entrants ≥ 13 years old)	2nd dose: 4 weeks to 3 months after 1st dose

* Note: DTP, DTaP, DT doses received previously are counted toward meeting the 3-dose tetanus-diphtheria immunization requirement for this age group.

CALIFORNIA SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent record (cumulative folder) as defined in Section 49068 of the Education Code and shall transfer with that record. Local health departments shall have access to this record in schools, child care facilities, and family day care homes.

This record must be completed by school and child care personnel from an immunization record provided by parent or guardian. See reverse side for instructions.

Student Name _____ Sex: M F Birthdate _____ Place of Birth _____

Name of Parent or Guardian _____ Address _____ City _____ ZIP _____

Telephone _____ Race/Ethnicity: White, not Hispanic Hispanic Black Other: _____

VACCINE	DATE EACH DOSE WAS GIVEN					Booster
	1st	2nd	3rd	4th	5th	
POLIO (OPV or IPV)						
DTP/DTap/DT/d (Diphtheria, tetanus and [acellular] pertussis OR tetanus and diphtheria only)						
MMR (Measles, mumps, and rubella)						
HIB (Required only for child care and preschool)						
HEPATITIS B						
VARICELLA (Chickenpox)						
HEPATITIS A (Not required)						

TB SKIN TESTS	Type* <input type="checkbox"/> PPD-Mantoux <input type="checkbox"/> Other	Date given	Date read	mm indur	Impression <input type="checkbox"/> Pos <input type="checkbox"/> Neg	CHEST X-RAY (Necessary if skin test positive) Film date: _____ Impression: <input type="checkbox"/> normal <input type="checkbox"/> abnormal
	<input type="checkbox"/> PPD-Mantoux <input type="checkbox"/> Other				<input type="checkbox"/> Pos <input type="checkbox"/> Neg	Person is free of communicable tuberculosis: <input type="checkbox"/> yes <input type="checkbox"/> no

*If required for school entry, must be Mantoux unless exception granted by local health department.

I. DOCUMENTATION
I certify that I reviewed a record of this child's immunizations and transcribed it accurately:
Date _____ Staff Signature _____
Record Presented was:
 Yellow California Immunization Record
 Out-of-state school record
 Other immunization record
Specify: _____

II. STATUS OF REQUIREMENTS
 A. All Requirements are met.
Date _____ / _____ / _____
 B. Currently up-to-date, but more doses are due later. Needs follow-up.
Exemption was granted for:
 C. Medical Reasons—Permanent
 D. Medical Reasons—Temporary
 E. Personal Beliefs

III. 7th GRADE ENTRY
 A. All Requirements are met.
Name _____ Date _____
 B. Currently up-to-date, but more doses are due later. Needs follow-up.
Name _____ Date _____

INSTRUCTIONS FOR SCHOOL OR CHILD CARE STAFF

1. Complete child's name and address information section, or ask parent or guardian to complete this section only. (This form is not to be sent home or given to parents to complete.)
2. School or child care personnel then fill in date (month/day/year) of each immunization the student has received from the Immunization Record presented by the parent or guardian. (If the date consists only of month and year for some doses, fill in month/xx/year; however, if either measles, rubella or mumps (or MMR) was received in the month of the first birthday, month/day/year is required.)
3. Determine if immunization requirements have been met, using the California "Immunization Requirements for Grades K-12," or "Immunization Requirements for Child Care," (available from Immunization Coordinators in local health departments), or other requirements guide.
4. Complete the Documentation and Status of Requirements box.
 - A. Fill in date and your signature as the staff member who reviewed and transcribed the immunization record presented by the parent or guardian. Check which type of record was presented.
 - B. If the child has met all immunization requirements, check box A and write in date.
 - C. If the child has not met all requirements, check box B. Child can be admitted only if up-to-date, e.g., no immunizations due currently. The child must be followed up as indicated in the "Guide to Immunization Requirements."
 - D. If a child is to be exempted for medical reasons, a doctor's written statement is required; the statement must include which immunization(s) is to be exempted and the specific nature and probable duration of the medical condition. If the medical exemption is permanent, the requirement for the designated immunization(s) is met; check box A and box C.* If the medical exemption is temporary, check box B and box D; this child must be followed up.*
 - E. If a child is to be exempted for reasons of personal beliefs, the parent or guardian must sign and date the affidavit below. No other parents should sign this affidavit. All requirements are met; check box A and box E.*

PERSONAL BELIEFS AFFIDAVIT TO BE SIGNED BY PARENT OR GUARDIAN—IMMUNIZATION

I hereby request exemption of the child, named on the front, from the immunization requirements for school/child care entry because all or some immunizations are contrary to my beliefs. I understand that in case of an outbreak of any one of these diseases, the child may be temporarily excluded from attending for his/her protection.

CREENCIAS PERSONALES: ESTA DECLARACIÓN JURADA DEBE SER FIRMADA POR EL PADRE O LA MADRE O EL GUARDIÁN
Solicito por la presente la dispensa de mi hijo, nombrado en el reverso, de los requisitos para vacunas de la entrada a la escuela/guardería ya que algunas o todas de las vacunas son opuestas a mis creencias. Comprendo que en caso de un brote en la comunidad de alguna de estas enfermedades, mi hijo puede ser excluido temporalmente de la escuela/guardería por su propia protección.

Signature (Firma) _____

Date (Fecha) _____

Applicable only in those jurisdictions where the Tuberculosis Assessment is required for school entry

Personal Beliefs Affidavit to be Signed by Parent or Guardian—Tuberculosis

I hereby request exemption of the child named on the front from the tuberculosis assessment requirement for school/child care entry because this procedure(s) is contrary to my beliefs. I understand that should there be cause to believe that my child is infected with active tuberculosis or should there be a tuberculosis outbreak, my child may be temporarily excluded from school.

Creencias Personales: Declaración Jurada Debe ser Firmada por el Padre o la Madre o el Guardián

Solicito por la presente la dispensa de mi hijo, nombrado en el reverso, de los requisitos para la evaluación de la tuberculosis (tisis) de la entrada a la escuela ya que esta evaluación es opuesta a mis creencias. Comprendo que si hay razón para sospechar que mi hijo sufra de la tuberculosis activa o si hay un brote de la tuberculosis, mi hijo puede ser excluido de la escuela.

Signature (Firma) _____

Date (Fecha) _____

* Names of all children who are exempt should be maintained on an exempt roster for immediate identification in case of disease outbreak in the community.

COMPROBANTE DE IMMUNIZACION ESCOLAR DE CALIFORNIA

Este registro es parte del historial permanente del estudiante (carpeta acumulativa) según se define en la Sección 49068 del Código de Educación y será transferido con dicho historial. Los departamentos de salud locales tendrán acceso a este registro en las escuelas, instalaciones de guardería y hogares de guardería familiar.

Este registro debe ser completado por el personal de la escuela y guardería en base a un registro de inmunización provisto por el padre, la madre o el tutor. Las instrucciones se encuentran en el reverso de este documento.

Nombre del estudiante _____ Sexo: M F Fecha de nacimiento _____ Lugar de nacimiento _____

Nombre del padre, de la madre o del tutor _____ Raza/Grupo étnico: Blanco, no hispano Hispano Negro Otro: _____ Dirección _____ Código Postal _____

Teléfono _____ Por el día _____ Por la noche _____ Ciudad _____

VACUNA	FECHA EN QUE SE ADMINISTRO CADA DOSIS					Refuerzo
	1ra.	2da.	3ra.	4ta.	5ta.	
POLIO (OPV o IPV)	/ /	/ /	/ /	/ /	/ /	/ /
DTP/DaP/DT/Td (Difteria, tétano y pertusis [acelular] O tétano y difteria solamente)	/ /	/ /	/ /	/ /	/ /	/ /
MMR (sarampión, paperas y rubéola)	/ /	/ /	/ /	/ /	/ /	/ /
HIB (Haemophilus influenza tipo B) (Requerida para guarderías solamente)	/ /	/ /	/ /	/ /	/ /	/ /
HEPATITIS B	/ /	/ /	/ /	/ /	/ /	/ /
VARICELA	/ /	/ /	/ /	/ /	/ /	/ /
HEPATITIS A (No requerida)	/ /	/ /	/ /	/ /	/ /	/ /

I. DOCUMENTACION
 Certificado que revise el comprobante de las inmunizaciones de este niño/a y que lo transcriba con precisión:
 Fecha _____ / _____ / _____
 Firma del Personal _____
 El comprobante presentado fue:
 Comprobante Amatillo de Inmunizaciones de California
 El historial de una escuela fuera del estado
 Otro comprobante de inmunización
 Especifique: _____
II. ESTADO DE LOS REQUISITOS
 A. Todos los requisitos quedan cumplidos.
 Fecha _____ / _____ / _____
 B. Actualmente al día, pero dosis adicionales serán necesarias más adelante. Necesita seguimiento.
 Se hizo una excepción por:
 C. Razones médicas—permanentes
 D. Razones médicas—temporales
 E. Creencias personales
III. REGISTRO DE 7º GRADO
 A. Todos los requisitos están cumplidos.
 B. Actualmente al día, pero dosis adicionales serán necesarias más adelante. Necesita seguimiento.
 Nombre _____ Fecha _____
 Nombre _____ Fecha _____

RADIOGRAFIA DE PECHO
 (Necesaria si la prueba cutánea es positiva)
 Fecha de la Radiografía _____ / _____ / _____
 Impresión: normal anormal
 La persona está libre de tuberculosis contagiosa: sí no

Tipo*	Fecha en que administró	Fecha en que fue leído	mm	Indur	Impresión
PPD-Mantoux	/ /	/ /			<input type="checkbox"/> Pos <input type="checkbox"/> Neg
Otro	/ /	/ /			<input type="checkbox"/> Pos <input type="checkbox"/> Neg
PPD-Mantoux	/ /	/ /			<input type="checkbox"/> Pos <input type="checkbox"/> Neg
Otro	/ /	/ /			<input type="checkbox"/> Pos <input type="checkbox"/> Neg

* Si se requiere para el ingreso a la escuela, debe ser Mantoux o menos que el departamento de salud local haga una excepción.

INSTRUCCIONES PARA EL PERSONAL ESCOLAR Y DE GUARDERIA

1. Llene la sección de información del nombre del niño/a y la dirección o pídale al padre/madre o tutor que llene esta sección solamente. (Este formulario no debe ser enviado a casa ni dado a los padres para que lo llenen.)
2. El personal escolar o de guardería luego llena la fecha (día/mes/año) de cada inmunización que el estudiante recibió en base al Registro de Inmunización presentado por el padre/madre o tutor. (Si la fecha consta solamente del mes y el año para algunas dosis, llene el xx/mes/año; sin embargo, si recibió una inmunización contra el sarampión, la rubéola o las paperas (o MMR) en el mes del primer cumpleaños, se requiere el día/mes/año.)
3. Determine si se han cumplido los requisitos de inmunización utilizando la "Guía de Inmunizaciones Requerida para el Ingreso a la Escuela" de California, o la "Guía de Inmunizaciones Requeridas para las Guarderías". (se puede obtener de parte de los Coordinadores de Inmunización en los departamentos de salud locales) u otra guía de requisitos.
4. Llene el casillero de Documentación y del Estado de los Requisitos.

- A. Llene la fecha y ponga su firma como miembro del personal que revisó y transcribió el registro de inmunización presentado por el padre/madre o tutor. Indique qué tipo de registro fue presentado.
- B. Si el niño/a ha cumplido con todos los requisitos de inmunización, marque el casillero A, y anote la fecha.
- C. Si el niño/a no ha cumplido con todos los requisitos, marque el casillero B. El niño/a puede ser admitido sólo si está actualizado, es decir en la actualidad no le falta ninguna vacuna. Al niño/a le deben hacer seguimiento según lo indica la "Guía de Requisitos de Inmunización".
- D. Si un/a niño/a ha de ser eximido por razones médicas, se requiere una declaración por escrito del médico; la declaración debe incluir qué inmunización(es) ha(n) de ser exceptuada(s) y la naturaleza específica y duración probable de la condición médica. Si la exención médica es permanente, el requisito de la(s) inmunización(es) designada(s) queda cumplido; marque el casillero A y el casillero C*. Si la exención médica es temporal, marque el casillero B y el casillero D; a este/a niño/a le deben hacer seguimiento.*
- E. Si un/a niño/a ha de ser eximido(a) por razones de creencias personales, el padre/madre o el tutor debe firmar y fechar la declaración jurada que figura a continuación. Ningún otro padre debe firmar esta declaración jurada. Todos los requisitos quedan cumplidos; marque el casillero A y el casillero E.*

LA DECLARACION JURADA DE CREENCIAS PERSONALES DEBE SER FIRMADA POR EL PADRE, LA MADRE O EL TUTOR — INMUNIZACION
 Solicito por la presente que se exima al niño, mencionado en el reverso de este documento, de los requisitos de inmunización para el ingreso a la escuela/guardería debido a que todas o algunas de las inmunizaciones van en contra de mis creencias. Comprendo que en el caso de un brote de cualquiera de estas enfermedades, el niño podría ser temporalmente excluido de la escuela/guardería para su protección.

Firma _____

Fecha _____

Aplicable solamente en aquellas jurisdicciones donde se requiere la Evaluación de la Tuberculosis para ingresar a la escuela

La declaración jurada de creencias personales debe ser firmada por el padre o la madre o el tutor — Tuberculosis

Solicito por la presente que se exima al niño, mencionado en el reverso de este documento, del requisito de evaluación de tuberculosis para ingresar a la escuela/guardería debido a que este procedimiento va en contra de mis creencias. Comprendo que si hubiera causa para pensar que mi hijo está infectado con tuberculosis activa o si hubiera un brote de tuberculosis, mi hijo podría ser excluido temporalmente de la escuela.

Firma _____

Fecha _____

* Los nombres de todos los niños eximidos deben ser mantenidos en una lista de exención para efectuar una identificación inmediata en caso de un brote de enfermedad en la comunidad.

For Reference Only

This is a Spanish translation of the California School Immunization Record (CSIR or PM 286), here included for reference. CSIRs are *not* available as shown here in Spanish. However, on the regular version, the parent signature blocks include both Spanish and English text.

SAN FRANCISCO UNIFIED SCHOOL DISTRICT POLICY

Health examination, immunization, and tuberculosis assessment requirements for:

- 1) INITIAL SCHOOL DISTRICT ENROLLMENT INTO KINDERGARTEN OR FIRST GRADE
- 2) INITIAL SCHOOL DISTRICT ENROLLMENT INTO GRADES 2 THROUGH 12.

Rationale Assembly Bill 52 (chaptered September 8, 1991) strengthens prior state law (Child Health and Disability Prevention Program PM 171 A) making it mandatory to exclude First grade students for up to 5 days if lacking evidence of having a physical examination (or waiver). The penalty to School Districts is that the Superintendent of Public Instruction may withhold ADA to the District for any child for whom a certificate or waiver is not obtained. The number of parent/guardians waivers must not exceed 5 percent of the first grade enrollment. A report is compiled by the District each school year and submitted to the State in collaboration with Child Health and Disability Prevention Program staff of San Francisco Department of Public Health.

Further, California Administrative Code, Title 17, and Board Policy P5142 require that students have various immunizations according to an age-appropriate schedule will be denied enrollment if lacking evidence of same or a parent/guardian waiver is on file. In addition to this, The County of San Francisco requires verification of absence of active infectious tuberculosis prior to school entry.

To simplify entry requirements for Kindergarten and grade one, a Board policy was adopted 6-4-91 to amend Policy 5142 making the physical examination a requirement upon initial entry to either Kindergarten or grade one. This consolidated the tasks for school staff and lessened the confusion for parents/guardians when requirements for immunizations, tuberculosis screening and physical examinations were on different time schedules.

The policy statement below combines the local and state requirements for new enrollees.

Proposed Policy Revision

Parents/guardians of new enrollees in San Francisco Unified School District in either kindergarten or first grade are required to submit a completed physical examination in addition to records of having completed immunizations and a tuberculosis assessment before school entry. The physical examination for kindergarteners; must be done between March and September of the same year that they enter school; for first graders, the examination must be done not more than 18 months prior to school entry. Lack of evidence of a physical examination, immunizations according to an age appropriate schedule or the results of a tuberculosis assessment will result in denial of enrollment. Parents/guardians may sign a waiver indicating that all or any of these requirements are contrary to belief. No more than 5% of parents/guardians in any school or in the District as a whole may substitute the waiver for evidence of having met the entry requirements.

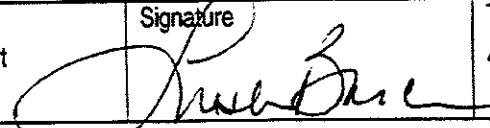
Prior to school enrollment, parents/guardians of all new enrollees in grades 2 through 12, must submit evidence of having completed immunizations according to an age appropriate schedule and the results of a tuberculosis assessment. In grades 2 through 12, a physical examination is not required. As with grades K and 1, lack of evidence or waiver will result in denial of enrollment.

Parents/guardians of all entering students lacking requirements will be advised of the availability of health services in the community and of the free Child Health and Disability Prevention Programs for which they may be eligible.

Passed by Board on 10-13-92

Directive to Administrators (Specify which administrators) All School Site Administrators	WAD Date (Wednesday) February 8, 2006	WAD No. 06-298	Page 1 of 1
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Subject Immunization requirements for homeless children and youth	Date Due Now	Not Applicable After NA
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From Trish Bascom	Title Executive Director, School Health Programs Department	Signature 	Telephone 415-242-2615
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Inform

Certificated staff Classified staff Parents Other _____

Weekly Administrative Directive

WHO? Any student enrolled in SFUSD schools considered to be homeless, including children living in "emergency or transitional shelters" or "awaiting foster care placement".

WHAT? Schools shall immediately enroll the homeless/foster child/youth, even if the child/youth is unable to produce records normally required for enrollment, such as previous academic records, immunization records, proof of residency, or other documentation. [McKinney-Vento Act-SEC.722(g)(3)(C)(i)]

If the child/youth needs to obtain immunizations or medical records, the enrolling school shall immediately refer the parent/guardian of the child/youth to the district's homeless liaison. [McKinney-Vento Act-SEC.722(g)(3)(C)(ii)]

The parent/guardian may have 7-14 days within which to bring the records directly to the school.

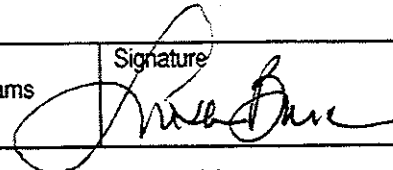
If a dispute arises over school enrollment, the child/youth shall be immediately admitted to the school in which enrollment is sought, pending resolution of the dispute.
[McKinney-Vento Act-SEC.722(g)(3)(C)(iii)]

WHY? The McKinney-Vento Assistance Act ensures educational rights and protections for homeless and foster children and youth.

HOW? Rosalinda Del Moral – District Homeless Liaison for Families in Transition Program, (415) 695-5569
Dolores Abeyta- Educational Placement Counselor, (415) 241-6136
School Health Programs- Nurse-of-the-Day (415) 242-2615

National Organizations:

- National Coalition for the Homeless www.nationalhomeless.org
- National Law Center for Homelessness and Poverty www.nlchp.org
- National Association of the Education of Homeless Children and Youth www.naehcy.org
- National Network for Youth www.NN4Youth.org
- National Center for Homeless Education (NCHE) www.serve.org/nche
Diana Bowman, Director - helpline:1-800-308-2145; email: homeless@serve.org
- U.S. Department of Education www.ed.gov/OFFICES/CEP
Gary Rutkin, Federal Coordinator; McKinney-Vento Program; email: gary.rutkin@ed.gov

Approved	Cabinet Member Trish Bascom	Title Executive Director, School Health Programs Department	Signature 
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SAN FRANCISCO UNIFIED SCHOOL DISTRICT WEEKLY ADMINISTRATIVE DIRECTIVE (WAD)



HEALTH FORM/PHYSICAL EXAM FORM INSTRUCTIONS

All Kindergarten students are required to have a Physical Exam Form on file. The form is to be completed after March 1st of their kindergarten entrance. (Please see the existing SFUSD Board Policy).

- The top portion of the form must be completed, signed and dated by the parent/guardian.
- This form must be signed/stamped by the medical provider.
- If the physical exam occurred prior to March, the parent/ guardian must take the form to the provider and have the form updated by the provider.
- The reverse side has information/requirements for immunizations, TB, screenings and health exam requirements.

San Francisco Unified School District - School Health Form

Completed by Parent or Caregiver: _____ Birthdate: _____ month/day/year _____ Male Female School: _____
 Child's Name: _____ Phone: _____ Home _____ / Cell _____ / Work _____ Grade: _____
 Address: _____ Street _____ Zip _____ Signature of Parent/Caregiver _____ Date _____

Release of Health Information: I give permission to share the results of this examination with the School

NOTE: Kindergarten entrance physical examination to be done no earlier than March of the year the child enters Kindergarten

Completed by health provider:

IMMUNIZATION RECORD (EACH child should have a completed or updated official/ yellow Immunization Record)

Vaccine	Dose given Month / Day / Year					Tuberculin Skin Test (Mantoux/PPD) Date: _____
	1 st	2 nd	3 rd	4 th	5 th	
Polio:						Induration: _____ mm Impression: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
DPT/DaP (Diphtheria, Pertussis, Tetanus)						Chest X-Ray/RX: required with Positive TB Skin Test
Td/DT (Tetanus, Diphtheria)						CXR Date: _____ Impression: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Hib (Haemophilus influenza type B)						RX treatment & duration: _____
MMR (Measles, Mumps, Rubella)						<input type="checkbox"/> Child has no risk factors for TB and does not require TB test *see back for risk factors _____
Hepatitis B						Health Provider Signature _____
Varicella (Chickenpox)						Had Varicella disease - Approximate date _____

HEALTH EXAMINATION - Date of Exam _____

Health/Developmental History	Results:	Relevant findings:	Follow-up/Referral Needed :
Physical Examination	Ht: _____ BP: _____ Wt: _____ BMI: _____ %		
Dental Assessment			
Developmental Evaluation			
Vision Screening	R: 20/ _____ L: 20/ _____		
Audiometric (hearing) Screening	Right: _____ 1000 _____ 2000 _____ 4000 _____ Left: _____		
Nutritional Assessment			
Lab Tests	Urine _____ Lead _____ Blood test for anemia _____		
Other			

(If you do not want your child to have an exam, you may sign the waiver form, PM 171B, obtained from your child's school) See other side for more details.

- Examination revealed no condition relevant to the school program, e.g. allergies, asthma, cardiac condition, diabetes, epilepsy, etc.
- Medical condition identified - emergency care plan attached (emergency care plan template can be downloaded at http://portal.sfusd.edu/template/default.cfm?page=chief_dev.health.MedicalForms)
- Medication taken at school - Name of medication: _____ Medication taken at home - Name of medication: _____
(If medication is taken at school, complete a medication form for each medication (medication form template can be downloaded at http://portal.sfusd.edu/template/default.cfm?page=chief_dev.health.MedicalForms)
- Restriction from physical activity - please specify _____

Name of Health Provider: _____ Child under my care since _____ Date: _____
 Address: _____ Signature of Health Provider: _____
 Phone: _____

GUIDE TO IMMUNIZATIONS REQUIRED FOR SCHOOL ENTRY

Grades K-12

REFERENCE: Health and Safety Code, Division 105, Part 2, Chapter 1, Sections 120325-120380; California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 8, Sections 6000-6075

IMMUNIZATION REQUIREMENTS: To enter or transfer into public and private elementary and secondary schools (grades kindergarten through 12), children under age 18 years must have immunizations as outlined below.

VACCINE	REQUIRED DOSES
Polio	4 doses at any age, but... 3 doses meet requirement for ages 4–6 years if at least one was given on or after the 4th birthday; 3 doses meet requirement for ages 7–17 years if at least one was given on or after the 2nd birthday.
Diphtheria, Tetanus, and Pertussis Age 6 years and under (<i>Pertussis is required</i>) DTP, DTaP or any combination of DTP or DTaP with DT (diphtheria and tetanus) Age 7 years and older (<i>Pertussis is not required</i>) Td, DT, or DTP, DTaP or any combination of these 7th grade Td booster	5 doses at any age, but... 4 doses meet requirements for ages 4–6 years if at least one was on or after the 4th birthday. 4 doses at any age, but... 3 doses meet requirement for ages 7–17 years if at least one was on or after the 2nd birthday. If last dose was given before the 2nd birthday, one more (Td) dose is required. 1 dose not required but recommended if more than 5 years have passed since last DTP, DTaP, DT, or Td dose.
Measles, Mumps, Rubella (MMR) Kindergarten 7th grade Grades 1–6 and 8–12	2 doses both on or after 1st birthday. 2 doses both on or after 1st birthday. 1 dose must be on or after 1st birthday.
Hepatitis B Kindergarten 7th grade	3 doses at any age 3 doses at any age or 2 doses of 2 dose formulation
Varicella Kindergarten Out-of-state entrants (grades 1–12)	1 dose 1 dose for children under 13 years; 2 doses are needed if immunized on or after 13th birthday.

EXEMPTIONS: The law allows (a) parents/guardians to choose an exemption from immunization requirements based on their personal beliefs, and (b) physicians of children to elect medical exemptions. The law does not allow parents/guardians to elect an exemption simply because of inconvenience (a record is lost or incomplete and it is too much trouble to go to a physician or clinic to correct the problem). See the back of the blue California School Immunization Record (PM 286) for instructions and the affidavit to be signed by parents/guardians electing the personal beliefs exemption. For children with medical exemptions, the physician's written statement should be stapled to the CSIR. Schools should maintain an up-to-date list of pupils with exemptions, so they can be excluded quickly if an outbreak occurs.

TB Skin Test (with result).....Given in the United States within 1 year before first admission to school in San Francisco

OR

Signature of examiner attesting to no risk factors for TB

Risk Factors for TB in Children

- Have a family member or contacts with history of confirmed or suspected TB
- Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America)
- Adopted from any high-risk area
- Travel to countries with high rate of TB
- Live in out-of-home placements
- Have, or are suspected to have, HIV infection*
- Live with an adult with HIV seropositivity
- Live with an adult who has been incarcerated in the last five years
- Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents of nursing homes
- Have contact with individuals(s) with positive TB skin test(s)
- Have abnormalities on chest X-ray suggestive of TB
- Have clinical evidence of TB

* Screening should be performed by CXR in addition to skin test and symptom review in HIV infected or suspected HIV, other immunocompromised conditions or if child is taking immunosuppressive agents such as chronic prednisone or TNF blockers

THE KINDERGARTEN/FIRST GRADE HEALTH EXAMINATION

Preparticipation Physical Evaluation

HISTORY

DATE OF EXAM _____

Name _____ Sex _____ Age _____ Date of birth _____
 Grade _____ School _____ Sport(s) _____ Phone _____
 Address _____
 Personal physician _____
In case of emergency, contact
 Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers below.
Circle questions you don't know the answers to.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have an ongoing or chronic illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a rash or hives develop during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member or relative died of heart problems or of sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out, become unconscious, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you cough, wheeze, or have trouble breathing during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---|----------------------------------|------------------------------------|
| 10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had a sprain, strain, or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, check appropriate box and explain below.</i> | | |
| <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/calf |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Upper arm | | <input type="checkbox"/> Foot |
| 13. Do you want to weigh more or less than you do now? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you lose weight regularly to meet weight requirements for your sport? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Record the dates of your most recent immunizations (shots) for: | | |
| Tetanus _____ | Measles _____ | |
| Hepatitis B _____ | Chickenpox _____ | |

FEMALES ONLY

16. When was your first menstrual period? _____
 When was your most recent menstrual period? _____
 How much time do you usually have from the start of one period to the start of another? _____
 How many periods have you had in the last year? _____
 What was the longest time between periods in the last year? _____

Explain "Yes" answers here: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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Preparticipation Physical Evaluation

PHYSICAL EXAMINATION

Name _____		Date of birth _____	
Height _____	Weight _____	% Body fat (optional) _____	Pulse _____ BP _____ / _____ (____ / _____, ____ / _____)
Vision R 20/ _____	L 20/ _____	Corrected: Y N	Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

* Station-based examination only

CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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CALIFORNIA SCHOOL IMMUNIZATION LAW
EXEMPTIONS INFORMATION SHEET

Here is information about exemptions from the immunizations required by the California School Immunization Law.
The Law allows these exemptions.

- *1. **PERMANENT MEDICAL EXEMPTION:** If your child has a medical condition which permanently rules out one or more vaccines, your child can be exempted from that immunization(s) requirement. A written statement from a physician must be presented at registration. It must state that there is a medical condition which permanently rules out immunization(s), and which immunization(s) your child cannot receive. It must be signed by the physician.

- *2. **TEMPORARY MEDICAL EXEMPTION:** If your child has a temporary medical condition which rules out one or more immunizations, or your physician wishes to delay an immunization, your child can be temporarily exempted from the requirement. A written statement from the physician must be presented at registration. This statement must indicate that there is a medical condition which rules out immunization(s) temporarily, how long it will last, and which immunization(s) must be postponed. It must be signed by the physician.

3. **MEASLES DISEASE EXEMPTION:** If a physician provides a written statement that your child has had measles disease, your child can be exempted from the measles requirement. The signed statement must be presented at registration.

4. **RUBELLA DISEASE EXEMPTION:** If a physician provides a written statement that your child has had laboratory-confirmed rubella disease, your child can be exempted from the rubella requirement. The signed statement must be presented at registration.

5. **MUMPS DISEASE EXEMPTION:** If a physician provides a written statement that your child has had laboratory-confirmed mumps disease, your child can be exempted from the mumps requirement. The signed statement must be presented at registration.

6. **VARICELLA (CHICKENPOX) EXEMPTION:** If a physician has documented that your child has had chickenpox disease, your child can be exempted from the varicella requirement. The immunization record showing physician documentation must be presented at registration.

- *7. **PERSONAL BELIEFS EXEMPTION:** If immunization is against your religious or personal beliefs, you will be asked to sign an affidavit at the time of registration. Your child will then be exempt from the immunization requirements.

*NOTE: If your child is exempt because of 1, 2, or 7 above, and there is a disease outbreak, the school may be ordered by the Health Department to temporarily exclude your child for his/her protection.

The California Health and Safety Code, Division 105, Part 2, Chapter 1, Sections 120325-120380 establishes the immunizations required and exemptions. Regulations to implement the law are contained in the California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 8, 6000-6075.

IMM-408E (5/02)

LEY DE VACUNACIÓN ESCOLAR DE CALIFORNIA

HOJA DE INFORMACIÓN DE EXENCIONES

Esta hoja contiene información sobre las exenciones de las vacunas requeridas por la Ley de Vacunación Escolar de California.

La ley permite las siguientes exenciones:

- *1. **EXENCIÓN MÉDICA PERMANENTE:** Si su hijo tiene un problema médico que impide permanentemente que le apliquen una o más vacunas, su hijo puede estar exento del requisito de esa vacuna. Deberá presentar una declaración escrita por un médico cuando inscriba a su hijo. La declaración deberá decir que su hijo padece de un problema médico que impide permanentemente la aplicación de una o más vacunas y debe especificar qué vacuna(s) no se deben aplicar al niño. Tiene que estar firmada por el médico.
- *2. **EXENCIÓN MÉDICA TEMPORAL:** Si su hijo tiene un problema médico temporal que impide que le apliquen una o más vacunas, o si su médico desea aplazar una vacunación, su hijo puede quedar exento temporalmente del requisito. Usted debe presentar una declaración escrita por un médico cuando inscriba a su hijo. La declaración deberá decir que su hijo padece de un problema médico que impide temporalmente la aplicación de una o más vacunas y el tiempo que durará, y debe especificar qué vacuna(s) se debe(n) aplazar. Tiene que estar firmada por el médico.
3. **EXENCIÓN DEL SARAMPIÓN:** Si un médico escribe una declaración que dice que su hijo tuvo sarampión, su hijo puede estar exento del requisito de vacunarse contra el sarampión. Debe presentar la declaración cuando inscribe a su hijo.
4. **EXENCIÓN DE LA RUBÉOLA:** Si un médico escribe una declaración que dice que su hijo tuvo rubéola y que ese hecho fue confirmado por un laboratorio, su hijo puede estar exento del requisito de vacunarse contra la rubéola. Debe presentar la declaración cuando inscribe a su hijo.
5. **EXENCIÓN DE LAS PAPERAS:** Si un médico escribe una declaración que dice que su hijo tuvo paperas y que ese hecho fue confirmado por un laboratorio, su hijo puede estar exento del requisito de vacunarse contra las paperas. Debe presentar la nota cuando inscribe a su hijo.
6. **EXENCIÓN DE LA VARICELA:** Si un médico documentó que su hijo tuvo varicela, su hijo puede estar exento del requisito de vacunarse contra la varicela. Debe presentar los registros de vacunación que muestran la documentación del médico cuando inscribe a su hijo.
- *7. **EXENCIÓN POR CREENCIAS PERSONALES:** Si la vacunación es contraria a sus creencias religiosas o personales, se le pedirá que firme una declaración jurada cuando inscriba a su hijo. Su hijo quedará exento de los requisitos de vacunación.

*NOTA: Si su hijo está exento por los motivos 1, 2 o 7 que anteceden, y hay un brote de enfermedad, es posible que el Departamento de Salud ordene a la escuela que excluya temporalmente a su hijo para su protección.

The California Health and Safety Code, Division 105, Part 2, Chapter 1, Sections 120325-120380 establishes the immunizations required and exemptions. Regulations to implement the law are contained in the California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 8, 6000-6075.

IMM-4885 (5/02)

SAN FRANCISCO WAIVER STATEMENT FOR IMMUNIZATION/HEALTH EXAMINATION

To be completed by Parent or Guardian

NAME OF CHILD Last _____ First _____ ADDRESS _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date _____	SCHOOL _____	Grade _____ Room _____
		NAME OF PARENT / CAREGIVER (Please Print) _____		
		Telephone: _____ Home _____ Business _____		

WAIVER STATEMENT

I have been informed of the immunizations required by the California State law and the health examination required by law for children entering school for the first time in California.

Check the appropriate box:

- I want my child to be excused from the immunization requirements due to personal beliefs.
 I do not want my child to receive the health examination.

OR I cannot obtain the health examination for my child because(specify):

Signature of Parent/Caregiver

Date

Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • 2006

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4-6 years	11-12 years	13-14 years	15 years	16-18 years
Hepatitis B ¹	HepB		HepB	HepB ¹	HepB			HepB Series							
Diphtheria, Tetanus, Pertussis ²				DTaP	DTaP	DTaP		DTaP		DTaP				Tdap	
Haemophilus influenzae type b ³				Hib	Hib	Hib ¹	Hib								
Inactivated Poliovirus				IPV	IPV		IPV				IPV				
Measles, Mumps, Rubella ⁴							MMR				MMR		MMR		
Varicella ⁵							Varicella					Varicella			
Meningococcal ⁶								Vaccines within broken line are for selected populations			MPSV4			MCV4	MCV4
Pneumococcal ⁷				PCV	PCV	PCV	PCV			PCV			PPV		
Influenza ⁸							Influenza (Yearly)						Influenza (Yearly)		
Hepatitis A ⁹											HepA Series				

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2005, for children through age 18 years. Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible. ■■■■ Indicates age groups that warrant special effort to administer those vaccines not previously administered. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever

any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective ACIP statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

■■■■ Range of recommended ages ■■■■ Catch-up immunization ■■■■ 11-12 year old assessment

- Hepatitis B vaccine (HepB).** *AT BIRTH:* All newborns should receive monovalent HepB soon after birth and before hospital discharge. **Infants born to mothers who are HBsAg-positive** should receive HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. **Infants born to mothers whose HBsAg status is unknown** should receive HepB within 12 hours of birth. The mother should have blood drawn as soon as possible to determine her HBsAg status; if HBsAg-positive, the infant should receive HBIG as soon as possible (no later than age 1 week). **For infants born to HBsAg-negative mothers,** the birth dose can be delayed in rare circumstances but only if a physician's order to withhold the vaccine and a copy of the mother's original HBsAg-negative laboratory report are documented in the infant's medical record. *FOLLOWING THE BIRTHDOSE:* The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1-2 months. The final dose should be administered at age ≥24 weeks. It is permissible to administer 4 doses of HepB (e.g., when combination vaccines are given after the birth dose); however, if monovalent HepB is used, a dose at age 4 months is not needed. **Infants born to HBsAg-positive mothers** should be tested for HBsAg and antibody to HBsAg after completion of the HepB series, at age 9-18 months (generally at the next well-child visit after completion of the vaccine series).
- Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. The final dose in the series should be given at age ≥4 years. **Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap - adolescent preparation)** is recommended at age 11-12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a Td booster dose. Adolescents 13-18 years who missed the 11-12-year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series. Subsequent **tetanus and diphtheria toxoids (Td)** are recommended every 10 years.
- Haemophilus influenzae type b conjugate vaccine (Hib).** Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months but can be used as boosters after any Hib vaccine. The final dose in the series should be administered at age ≥12 months.
- Measles, mumps, and rubella vaccine (MMR).** The second dose of MMR is recommended routinely at age 4-6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by age 11-12 years.

- Varicella vaccine.** Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons aged ≥13 years should receive 2 doses administered at least 4 weeks apart.
- Meningococcal vaccine (MCV4).** Meningococcal conjugate vaccine (MCV4) should be given to all children at the 11-12 year old visit as well as to unvaccinated adolescents at high school entry (15 years of age). Other adolescents who wish to decrease their risk for meningococcal disease may also be vaccinated. All college freshmen living in dormitories should also be vaccinated, preferably with MCV4, although **meningococcal polysaccharide vaccine (MPSV4)** is an acceptable alternative. Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high risk groups (see *MMWR* 2005;54 [RR-7]:1-21); use MPSV4 for children aged 2-10 years and MCV4 for older children, although MPSV4 is an acceptable alternative.
- Pneumococcal vaccine.** The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children aged 2-23 months and for certain children aged 24-59 months. The final dose in the series should be given at age ≥12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000; 49(RR-9):1-35.
- Influenza vaccine.** Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including, but not limited to, asthma, cardiac disease, sickle cell disease, human immunodeficiency virus [HIV], diabetes, and conditions that can compromise respiratory function or handling of respiratory secretions or that can increase the risk for aspiration), healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk (see *MMWR* 2005;54(RR-8):1-55). In addition, healthy children aged 6-23 months and close contacts of healthy children aged 0-5 months are recommended to receive influenza vaccine because children in this age group are at a substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5-49 years, the intranasally administered, live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2005;54(RR-8):1-55. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if aged 6-35 months or 0.5 mL if aged ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).
- Hepatitis A vaccine (HepA).** HepA is recommended for all children at 1 year of age (i.e., 12-23 months). The 2 doses in the series should be administered at least 6 months apart. States, counties, and communities with existing HepA vaccination programs for children 2-18 years of age are encouraged to maintain these programs. In these areas, new efforts focused on routine vaccination of 1-year-old children should enhance, not replace, ongoing programs directed at a broader population of children. HepA is also recommended for certain high risk groups (see *MMWR* 1999; 48(RR-12):1-37).

The Childhood and Adolescent Immunization Schedule is approved by:

Advisory Committee on Immunization Practices www.cdc.gov/nip/acip • American Academy of Pediatrics www.aap.org • American Academy of Family Physicians www.aafp.org



Directive to Administrators (<i>Specify which administrators</i>)		WAD Date (Wednesday)	WAD No.	Page 1 of 1
Middle School Administrator (Principal or Assistant Principal)		March 31, 2004		
Subject		Date Due	Not Applicable After N/A	
Required Immunizations for 6 th Graders(Hepatitis B and MMR #2)				
From TRISH BASCOM	Title Executive Director, School Health Programs Department	Signature		Telephone 415-242-2615
Inform <input type="checkbox"/> Certificated Staff <input type="checkbox"/> Classified Staff <input checked="" type="checkbox"/> Parents Other _____				
Weekly Administrative Directive				
<p>AB 381 requires that middle school students present proof of completion of hepatitis B and measles (MMR #2) by 7th grade. As hepatitis B vaccination is a multi-dose series with each dose spaced 1-5 months apart, you can achieve compliance more effectively by notifying the parents of incoming 6th grade to obtain needed shots or records during the summer.</p> <p>A form is provided for your convenience in three languages (English, Chinese, and Spanish). Please send them to your incoming 6th graders by US Mail, using the most current mailing labels available through the district office.</p> <p>As background information:</p> <ul style="list-style-type: none"> • Hepatitis B and measles are potentially fatal viral infections. • The vaccines are very effective in preventing these diseases. • AB 381 is an excellent "catch-up" strategy for students who have not completed these shots. • Sending this form NOW prevents loss of school time in the fall for medical appointments and reduces exclusion for non-compliance if the child reaches 7th grade with no or incomplete records. 				
Approved	Cabinet Member Trish Bascom	Title Executive Director, School Health Programs Department	Signature	

SAN FRANCISCO UNIFIED SCHOOL DISTRICT WEEKLY ADMINISTRATIVE DIRECTIVE (WAD)



Attention: PARENTS of INCOMING 6th GRADERS



You are required by law* to provide your child's Shot Record as proof of:
THREE doses of Hepatitis B
and the Second Measles (MMR) Shot

*California Law AB 381 requires proof of protection from deadly hepatitis B and measles.

- 1. If your child had these shots, s/he does NOT need more shots.**
 - Photocopy your child's shot record and staple it to this form or....
 - Have the health care provider fill out the bottom of this form.
- 2. If your child is missing any of these shots, take your child to the doctor now!**
 - The Hepatitis B shots take at least 4-6 months to complete. Please start them NOW.
 - If you have limited income, ask your health care provider about shots at low or no charge.
 - Have the health care provider fill out the bottom of this form.
- 3. On the first day of school, give this form to the homeroom teacher.**

STUDENT INFORMATION

Student's Name _____ Date of Birth _____
Address _____ Apt. _____
City _____ 941 _____ Home Telephone _____
Parent's Complete Name _____ Daytime Telephone _____

VACCINATION DATES

Dear Health Care Provider: please provide the dates of shots. Thank you!

*Hepatitis B #1 _____ Hep B #2 _____ Hep B #3 _____
Measles (MMR) #2 _____
Health Care Provider _____ Telephone _____
Address _____

*If the 2-dose vaccine is used, please note manufacturer and dose on this form. Thank you.

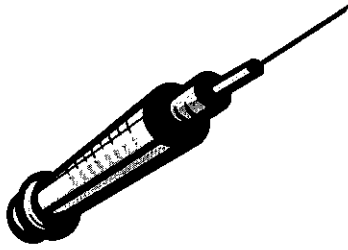
Principal

Assistant Principal

Counselors

This flyer was made possible by a health education grant from the Merck Vaccine Division and support from the San Francisco Immunization Coalition, a non-profit coalition of health organizations.

ATENCIÓN: PADRES DE FUTUROS ALUMNOS DEL 6° GRADO



Es necesario por ley* que compruebe que a su hija o hijo le hayan puesto las siguientes vacunas:

- ✓ La serie de 3 vacunas contra la Hepatitis B
- ✓ La segunda vacuna contra la Viruela(MMR)

*La ley AB381 en California requiere que demuestre haber sido vacunado contra Hepatitis B y Viruela

1. Si su hijo o hija ya ha recibido estas vacunas, **NO necesita ninguna otra.**
 - ❖ Por favor engrape una copia de la tarjeta de vacunación de su hija o hijo a esta forma; o,
 - ❖ Pídale a su proveedor de salud que llene la forma incluida en esta hoja.
2. Si a su hija(o) le falta alguna de esas vacunas ¡Llévela(o) a su médico lo antes posible!
 - ❖ Completar la serie de vacunas contra la Hepatitis B toma de 4 a 6 meses. Por favor comience cuanto antes.
 - ❖ Si sus ingresos son limitados, consulte a su proveedor de servicios médicos para obtener las vacunas a bajo costo o gratis.
 - ❖ Pídale a su proveedor de salud que llene la forma incluida en esta hoja.
3. Por favor lleve esta forma llena a la escuela el primer día de clases y hágasela llegar a la maestra de su hija o hijo.

INFORMACIÓN DEL(LA) ESTUDIANTE

Nombre de la(el) estudiante	Fecha de Nacimiento	
Domicilio	Depto.	
Ciudad	941	Teléfono
Nombre de Madre o Padre	Teléfono durante el día	

VACCINATION DATES

Dear Health Care Provider: please provide the dates of shots. Thank you!

*Hepatitis B #1	Hep B #2	Hep B #3
Measles (MMR) #2		
Health Care Provider Address	Telephone	

***If the 2-dose vaccine is used, please note manufacturer and dose on this form. Thank you.**

Director

Sub-Directora

Consejeros

Este volante fue patrocinado por la División de Vacunas Merck y el apoyo de la Coalición de Inmunización de San Francisco

Protect Your Baby...



from Whooping Cough!

Why Whooping Cough Is Serious:

- Whooping cough (pertussis) can cause babies to stop breathing or cough so much that they can't breathe. Infants and babies are especially at risk for pertussis and some die from it.
- Babies under 6 months of age are at highest risk of dying from whooping cough. Young children (2-10 years old) often get pertussis and have trouble breathing.

Ways to Protect Your Baby:

- For protection, your baby needs 3 DTaP shots by 15 months of age to prevent whooping cough.
- Ask everyone in your house to cover their mouths when coughing and to wash their hands often.



PROTECT YOUR BABY FROM WHOOPING COUGH BY GETTING DTaP

2 MONTHS 4 MONTHS
6 MONTHS 12 MONTHS 15 MONTHS

Proteja a su bebé...



... de la **tos ferina**

Por que es grave la tos ferina:

- La tos ferina puede hacer que los bebés dejen de respirar o que tosan tanto que no puedan respirar. Cada año cientos de bebés son hospitalizados por la tos ferina, y algunos mueren de esta enfermedad.
- Los bebés menores de 6 meses de edad tienen el más alto riesgo de enfermarse. Con frecuencia contraen la tos ferina de los padres y de otros familiares.

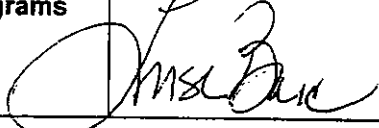

Maneras de proteger a su bebé:

- Para su protección, el bebé necesita 3 vacunas DTaP antes de cumplir los 6 meses de edad para prevenir la tos ferina.
- Puesto que la tos ferina se pasa por la tos, mantenga al bebé lejos de cualquier persona con tos.
- Para ayudarla que a los bebés libres de esta enfermedad, los padres y otros familiares pueden recibir la **nueva vacuna Tdap** para protegerse de la tos ferina (y del tétanos).
- ¡Pida a todos en su casa que se tapen la boca cuando tosan y que se laven las manos con frecuencia!



PROTEJA A SU BEBÉ. PROTEJA A SU FAMILIA. VACUNÉNSE.



To: ALL SCHOOL ADMINISTRATORS		WAD Date : February 5, 2003	WAD No. 299	Page 1 of 1
WAD Title : Varicella Immunization Requirement			Date Due NOW	Not Applicable
From : TRISH BASCOM (Cabinet member or approved by one below)	Title: Executive Director School Health Programs Department	Signature 		Telephone: (415) 242-2615
Inform <input checked="" type="checkbox"/> Certificated Staff <input checked="" type="checkbox"/> Classified Staff <input checked="" type="checkbox"/> Parents _____ Post on Bulletin Board Other _____				
<p>Administrative Directive</p> <p><u>Varicella Immunization (Vaccine) Requirement</u></p> <p>The California School Immunization Law requires that all children be up-to-date on their immunizations (shots). All children entering kindergarten or 1st grade (if the child did not attend kindergarten) are required to have a Varicella (chicken pox) vaccine (shot). This Law became effective July 1, 2001.</p> <p>If a child has already had chickenpox, his or her doctor can indicate this information on the immunization record to fulfill the entry requirement,</p> <p>Chickenpox is spread through the air as well as through contact with chickenpox blisters. It can spread rapidly between unimmunized children in the same school classroom.</p> <p>For more information on school immunization laws and vaccine-preventable diseases, parents should contact their physician, School Health Programs Department, or any local health department's immunization program. Other contacts are the Centers for Disease Control and Prevention (CDC):</p> <ul style="list-style-type: none"> • Call 1-800-232-2522 (English) • Call 1-800-232-0233 (Spanish) <p>Visit the National Immunization Program's web site at http://www.cdc.gov/nip</p> <p>As with all school immunization laws, California provides an exemption for medical reasons and personal beliefs.</p>				
Cabinet Member Gwen Chan		Title: Chief Development Officer	Signature 	
San Francisco Unified School Weekly Administrative Directive (WAD)				



San Francisco Unified School District
 School Health Programs Department
 1515 Quintara St.
 San Francisco, CA 94116
 Tel. 415/242-2615
 Fax: 242-2618
 www.sfusd.edu

SAN FRANCISCO UNIFIED SCHOOL DISTRICT

NOTICE OF INCOMPLETE HEALTH REQUIREMENTS

Student _____ Grade _____ Room _____ Date _____

Your child's health record in the school file does not provide proof that she/he has met all the requirements of the San Francisco Unified School District and California State Law. The rules are explained on the attached School Health Form.

YOUR CHILD NEEDS:

- Polio # _____
- DTaP/DT/Td# _____
- MMR (Measles-Mumps-Rubella) # _____
- Hepatitis B Dose # _____ of 3
 3 doses required for kindergarten entry
 3 doses required for 7th graders, effective 7/1/99
- Varicella (Chickenpox) # _____
- Physical Examination
- Updated TB test and result
- Proof of Treatment for Positive TB
- Chest X-Ray result
- Result for TB test on ____/____/____
- Had disease (approximate date) _____
- There are no medical records for your child at school. Please give the school secretary the complete immunization records; result of the last TB test and physical examination even though you may have already given a copy to the school district enrollment office.

PLEASE DO THE FOLLOWING IMMEDIATELY: Take your child with these forms to your medical provider or clinic, or to one of the clinics on the back of this form. Return the completed medical form or proof of appointment to the school secretary so that your child will not be excluded from school.

FAILURE TO COMPLY WILL RESULT IN YOUR CHILD BEING EXCLUDED FROM SCHOOL. PLEASE RETURN THE NEEDED DOCUMENTATION TO SCHOOL BY:

Monday Tuesday Wednesday Thursday Friday ____/____/____

If you do not understand the requirements or if you have problems meeting the requirements, the school's Health Worker or School Nurse listed below will be able to help you.

 School

 Health Worker/ School Nurse

**PUBLIC HEALTH CLINICS AND LOW COST/FREE CLINICS FOR IMMUNIZATION
& TUBERCULOSIS TESTS (PPD)– May 2006
CLÍNICAS DE SALUD PÚBLICAS Y CLÍNICAS GRATIS O PRECIO BAJO
公共衛生局和低收費或免費診所**

CASTRO MISSION HEALTH CENTER – 3850 17TH St 487-7500
Call by 1:00 pm for appointment for next day. Cost based on financial qualifications

CHINATOWN HEALTH CENTER – 1490 Mason Ave 364-7600
Immunizations and PPD by appointment. Cost based on financial qualifications

***MAXINE HALL HEALTH CENTER – 1301 Pierce St 292-1300**
Drop-in for immunizations and PPD, call first as schedule changes weekly. Must be in line by 7:30 am to receive immunizations. Free for children.

MISSION NEIGHBORHOOD HEALTH CENTER – 240 Shotwell 552-3870
Immunizations and PPD for Mission Neighborhood H.C. patients only

NATIVE AMERICAN HEALTH CENTER – 160 Capp St 621-8051
Immunizations and PPD by appointment. Sliding scale

NORTHEAST MEDICAL SERVICES – 1620 Stockton St 391-9686
Immunizations and PPD by appointment. Cost based on financial qualifications

OCEAN PARK HEALTH CENTER – 1351 24th Ave 682-1900
Immunizations and PPD for Ocean Park H.C. patients only

POTRERO HILL HEALTH CENTER – 1050 Wisconsin 648-3022
Appointment made through triage nurse. Free

S.F. GENERAL HOSPITAL FAMILY HEALTH CENTER – 995 Potrero 206-5252
Immunizations and PPD by appointment. Cost based on financial qualifications

S.F. GENERAL HOSPITAL PEDIATRICS – 1001 Potrero 206-8376 Immunizations and PPD by appointment. Cost based on financial qualifications

SFUSD SCHOOL HEALTH CENTER – 1515 Quintara 242-2615 Immunizations and PPD with physical exams. No private insurance accepted.

SILVER AVENUE HEALTH CENTER – 1525 Silver Ave 715-0300
Immunizations and PPD by appointment only. Cost based on financial qualifications

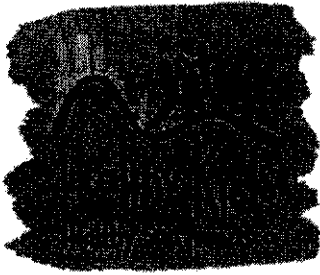
SOUTHEAST HEALTH CENTER – 2401 Keith St 671-7000
Immunizations and PPD by appointment only. (Same day or next day)
Cost based on financial qualifications

SOUTH OF MARKET HEALTH CENTER – 551 Minna St. 626-2951 Pediatric services by appointment Mon, Weds, Thurs 9-11 am. Cost based on financial qualifications

ST. ANTHONY'S CLINIC – 105 Golden Gate 241-8320
Immunizations and PPD by appointment. Registration required. Free

*Same day appointment

E-28



San Francisco Unified School District
 School Health Programs Department
 1515 Quintara St.
 San Francisco, CA 94116
 Tel. 415/242-2615
 Fax: 242-2618
 www.sfusd.edu

DISTRITO ESCOLAR UNIFICADO DE SAN FRANCISCO

NOTICIA DE REQUISITOS DE SALUD INCOMPLETOS

Estudiante: _____ Grado: _____ Salón: _____ Fecha: _____

El expediente médico de su hijo/a en la escuela muestra que el/ella no ha cumplido con los requisitos del Distrito Escolar de San Francisco y la Ley del Estado de California. Se explican las regulaciones al reverso de la forma adjunta, titulada School Health Form.

A su hijo/a le falta lo siguiente:

- Poliomelitis(Polio/OPV) # _____
- Difteria, Tosferina, Tétanos (DTaP/DT/Td)# _____
- Sarampión, Paperas, Rubeola MMR (Measles-Mumps-Rubella) # _____
- Hepatitis B dosis # _____ de 3
3 dosis son requeridas para entrar a Kinder
3 dosis son requeridas para entrar a 7th Séptimo grado efectivo Julio, 1999
- Varicela (Chickenpox) # _____
- Examen Físico (Physical Examination)
- Prueba de Tuberculina nueva con resultado (Updated TB test and result)
- Comprobante de tratamiento para reacción positiva de TB. (Proof of Treatment for Positive TB)
- Resultado de Radigrafía del pecho (Chest X-Ray result)
- Resultado de la prueba de Tuberculina de la fecha: ____ / ____ / ____
- Ha tenido o/ha sido expuesto a la varicela Fecha Aproximada _____
- No hay ningún record de salud de su hijo/a en los archivos de la escuela. Por favor entregue a la secretaria de la escuela lo siguiente lo antes posible: Resultado de la Tuberculina, Comprobante de Vacunas y Examen Físico, aunque usted ya los haya llevado a la oficina de matriculación del Distrito Escolar.

POR FAVOR HAGA LO SIGUIENTE INMEDIATAMENTE: Lleve a su hijo/a con estas formas a su médico o clinica o a una de las clínicas nombradas atrás de esta hoja. Debuelvalas llenas por el médico o traiga una prueba de que tiene cita, a la secretaria de la escuela para que su hijo/a no sea excluido de la escuela.

SI NO CUMPLE CON LO REQUERIDO. SU HIJO/A NO PODRA ASISTIR A CLASES POR FAVOR REGRESE LA DOCUMENTACION REQUERIDA ANTES DEL DIA:

Lunes Martes Miércoles Jueves Viernes ____ / ____ / ____

Si usted no entiende o tiene problemas en cumplir los requisitos, el/la trabajador/a de salud o enfermera

 Escuela
 SFUSD/SHPD 2006/07

 Trabajador/a de Salud/Enferma

**PUBLIC HEALTH CLINICS AND LOW COST/FREE CLINICS FOR IMMUNIZATION
& TUBERCULOSIS TESTS (PPD)– May 2006
CLÍNICAS DE SALUD PÚBLICAS Y CLÍNICAS GRATIS O PRECIO BAJO
公共衛生局和低收入或免費診所**

CASTRO MISSION HEALTH CENTER – 3850 17TH St 487-7500

Call by 1:00 pm for appointment for next day. Cost based on financial qualifications

CHINATOWN HEALTH CENTER – 1490 Mason Ave 364-7600

Immunizations and PPD by appointment. Cost based on financial qualifications

***MAXINE HALL HEALTH CENTER – 1301 Pierce St 292-1300**

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MISSION NEIGHBORHOOD HEALTH CENTER – 240 Shotwell 552-3870

Immunizations and PPD for Mission Neighborhood H.C. patients only

NATIVE AMERICAN HEALTH CENTER – 160 Capp St 621-8051

Immunizations and PPD by appointment. Sliding scale

NORTHEAST MEDICAL SERVICES – 1620 Stockton St 391-9686

Immunizations and PPD by appointment. Cost based on financial qualifications

OCEAN PARK HEALTH CENTER – 1351 24th Ave 682-1900

Immunizations and PPD for Ocean Park H.C. patients only

POTRERO HILL HEALTH CENTER – 1050 Wisconsin 648-3022

Appointment made through triage nurse. Free

S.F. GENERAL HOSPITAL FAMILY HEALTH CENTER – 995 Potrero 206-5252

Immunizations and PPD by appointment. Cost based on financial qualifications

S.F. GENERAL HOSPITAL PEDIATRICS – 1001 Potrero 206-8376 Immunizations and PPD by appointment. Cost based on financial qualifications

SFUSD SCHOOL HEALTH CENTER – 1515 Quintara 242-2615 Immunizations and PPD with physical exams. No private insurance accepted.

SILVER AVENUE HEALTH CENTER – 1525 Silver Ave 715-0300

Immunizations and PPD by appointment only. Cost based on financial qualifications

SOUTHEAST HEALTH CENTER – 2401 Keith St 671-7000

Immunizations and PPD by appointment only. (Same day or next day)

Cost based on financial qualifications

SOUTH OF MARKET HEALTH CENTER – 551 Minna St. 626-2951 Pediatric services by appointment Mon, Weds, Thurs 9-11 am. Cost based on financial qualifications

ST. ANTHONY'S CLINIC – 105 Golden Gate 241-8320

Immunizations and PPD by appointment. Registration required. Free

*Same day appointment



San Francisco Unified School District

School Health Programs Department

1515 Quintara Street

San Francisco, CA 94116-1273

Tel 415.242.2615

Fax 415.242.2618

http://portal.sfusd.edu/template/default.cfm?page=chief_dev.health

三藩市聯合校區
必須完成健康報告通知信

學生姓名 _____ 年級 _____ 課室 _____ 日期 _____

貴子弟在學校的健康記錄顯示未符合三藩市聯合校區和加州法律的要求。
現附上學校印有符合健康要求的說明表格。

貴子弟需要：

___ 小兒麻痺症防疫第___次 (IPV/POLIO)

___ 體格檢查 (P.E.)

___ 白喉，百日咳，破傷風第___次 (DTP)

___ 近期肺結核檢查和結果
(Update TB & Result)

___ 麻疹，腮腺炎，德國麻疹防疫第___次 (MMR)

___ 肺結核的治療證明
(Proof of Treatment)

___ 乙型肝炎防疫第___次 (Hep B)

___ X光照肺結果報告
(Chest X-Ray Result)

進入幼兒園需要三次

由一九九九年七月開始進入七年級需要三次

___ 肺結核檢查結果在
(Result for TB test on)

___ 水痘防疫第___次 (VARICELLA)

___/___/___

如果已經出過水痘，請將日期寫上 _____

(Had disease - approximate date)

___ 學校沒有貴子弟的健康記錄：包括所有防疫記錄，肺結核檢查結果報告和體格檢查，或許你已經交了一份給校區入學報名辦事處，但仍需要一份完整的防疫記錄給校方秘書。

請從速辦理下列事項：帶貴子弟和這些表格去見家庭醫生或到後頁所列之任何一間衛生局。並交還填妥之防疫注射記錄或是醫生預約紙給校方秘書，藉此貴子弟不會被停學。

不遵照這些要求將會導致貴子弟不準到學校上課。請在下列日期前將預防注射記錄和體格檢查的證明交回學校。

星期一 星期二 星期三 星期四 星期五， ___/___/___

如果你不明白以上的要求，或有困難去完成它，下面所寫的學校保健人員或護士可以幫助你。

學校 _____

保健人員 / 護士 _____

**PUBLIC HEALTH CLINICS AND LOW COST/FREE CLINICS FOR IMMUNIZATION
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Immunizations and PPD by appointment. Registration required. Free

*Same day appointment



ИЗВЕЩЕНИЕ О НЕВЫПОЛНЕНИИ ТРЕБОВАНИЙ ПО ЗДРАВООХРАНЕНИЮ
 (Notice of Incomplete Health Requirements)

Имя _____ Класс _____ № комнаты _____ Дата ____ / ____ / ____

Согласно медицинским данным хранящимся у администрации школы, у нас не имеется подтверждения о выполнении Вашим ребёнком всех требований Администрации Объединённых Школ г. Сан-Франциско (San Francisco Unified School District), а также Закона штата Калифорния по вопросам общественного здравоохранения. Правила излагаются в прилагаемом Формуляре по Вопросам Школы и Здоровья (School Health Form).

ВАШЕМУ РЕБЁНКУ ТРЕБУЮТСЯ:

Иммунизации и прививки:

- полиомиелит (Polio/OPV # _____)
- дифтерия, коклюш, столбняк (DPT/DT/Td # _____)
- свинка, корь и краснуха (MMR)
- свинка (measles)
- гепатит В (Hepatitis B). Прививка # _____ из 3х необходимых
- Ветрянка (Chickenpox) _____ Переболел

Следующие данные:

- полный медицинский осмотр
- дата последней проверки на туберкулёз и её результаты (не больше года тому назад)
- подтверждение о прохождении курса лечения
- результаты рентгеновых снимков лёгких
- результаты проверки на туберкулёз, даты _____
- школа не имеет медицинских-данных Вашего ребёнка. Пожалуйста, передайте секретарю школы полные сведения, подтверждающие наличие иммунизации (запись прививок), результаты последних проверок на туберкулёз и медицинский осмотр - даже в том случае, если Вы уже предъявили копию требуемых данных школьной администрации в момент регистрации ребёнка.

ПОЖАЛУЙСТА, БЕЗОТЛАГАТЕЛЬНО СДЕЛАЙТЕ СЛЕДУЮЩЕЕ: Вместе с Вашим ребёнком и с этими формулами обратитесь к обслуживающему Вас медицинскому персоналу или клинике, или посетите одну из указанных на обложке клиник. Во избежание исключения Вашего ребёнка из школы, верните школьному секретарю соответствующие заполненные медицинские формуляры, или подтверждение о назначении даты приёма у врача ("proof of appointment").

В СЛУЧАЕ НЕВЫПОЛНЕНИЯ ЭТИХ ТРЕБОВАНИЙ ВАШ РЕБЁНОК БУДЕТ ИСКЛЮЧЕН ИЗ ШКОЛЫ НАЧИНАЯ С:

понедельника вторника среды четверга пятницы ____ / ____ / ____

В случае, если Вам непонятны требования, или иных затруднений с их выполнением, Вам поможет нижеподписанный медицинский персонал школы.

**NHỮNG PHÒNG Y TẾ SAU DÂY NHẬN MEDI-CAL,
CÓ THỂ KHÁM MIỄN PHÍ HOẶC LÀ THU LỆ PHÍ THẤP**
**PUBLIC HEALTH CLINICS AND LOW COST/FREE CLINICS FOR
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*Same day appointment



San Francisco Unified School District
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TEL 415-242-2615
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www.sfusd.edu/health/shpd.html

SAN FRANCISCO UNIFIED SCHOOL DISTRICT

GIẤY BÁO VỀ VIỆC CHƯA HOÀN TẤT KÝ LỤC Y TẾ

Tên Học Sinh _____ Tên Họ _____ Tên _____ Lớp _____ Số Phòng _____ Ngày _____

Ký lục y tế tại trường học của con em quý vị chưa chỉ rõ con em đã hội đủ mọi điều kiện y tế qui định bởi Khu Liên Trường San Francisco và Luật tiểu bang California. Các điều lệ qui định được trình bày tại phần sau mẫu School Health Form đính kèm.

CON EM QUÍ VỊ CẦN:

- | | |
|---|--|
| <input type="checkbox"/> Chích ngừa Bệnh Tê Liệt liều số _____
(Polio# _____) | <input type="checkbox"/> Khám sức khỏe (Physical Exam) |
| <input type="checkbox"/> Chích ngừa Bệnh Yết-Hầu/Ho Gà/Phong Đòn Gánh liều số _____ (DPT/DT/TD # _____) | <input type="checkbox"/> Khám nghiệm bệnh lao gần nhất (Updated TB test and result) |
| <input type="checkbox"/> Chích ngừa Bệnh Sởi/Sưng Quai Bị/Phong Chấn liều số _____ (MMR # _____) | <input type="checkbox"/> Y chứng về điều trị bệnh lao (Proof Treatment for positive TB) |
| <input type="checkbox"/> Chích ngừa Bệnh Sưng Gan loại B liều số _____ với 3 lần (Hepatitis B Dose # _____ of 3)
* Cần phải có 3 liều lúc đi vào lớp mẫu-giáo
* Cần phải có 3 liều lúc đi vào lớp bảy, bắt đầu tháng bảy, năm 1999 | <input type="checkbox"/> Kết quả chụp hình phổi (Chest X-Ray result) |
| <input type="checkbox"/> Chích ngừa Bệnh Thủy-đậu (Varicella hoặc Chickenpox) | <input type="checkbox"/> Kết quả khám bệnh lao ngày _____/_____/_____(Result of TB test) |
| <input type="checkbox"/> Nhà trường không có hồ sơ y tế của con em. Xin đem nộp một bản sao ký lục chích ngừa hoàn chỉnh cho thư ký nhà trường: Kể cả kết quả khám nghiệm bệnh lao lần cuối, chứng nhận đã chích ngừa và khám sức khỏe; dù rằng quý vị từng đem nộp một bản sao cho Văn Phòng Ghi Tên Nhập Học của Học Khu. | <input type="checkbox"/> Có bị bệnh Thủy-đậu rồi |

XIN VUI LÒNG THỰC HIỆN GẤP VIỆC SAU ĐÂY: Đem theo những mẫu này cùng con em đến gặp nhân viên y tế hay chẩn y viện, hay là đến một trong những phòng y tế in tại trang sau mẫu này để khám. Hoàn trả mẫu khám sức khỏe, hoặc tờ giấy hẹn gặp bác sĩ cho thư ký nhà trường thì con em sẽ không bị cấm vô lớp.

KHÔNG TUÂN THEO ĐIỀU NÀY THÌ CON EM SẼ KHÔNG ĐƯỢC VÀO LỚP HỌC KỂ TỪ NGÀY THỨ:

Hai Ba Tư Năm Sáu Ngày _____/_____/_____

Nếu quý vị không hiểu rõ điều kể trên, hay là quý vị có những khó khăn để thực hiện điều đòi hỏi đó, nhân viên sức khỏe trường học hoặc là y tá trường học có tên sau đây có thể giúp họ.

Trưởng Học

Nhân Viên Sức Khỏe Trường Học/Y Tá Trường Học
(Health Worker) (School Nurse)

**NHỮNG PHÒNG Y TẾ SAU DÂY NHẬN MEDI-CAL,
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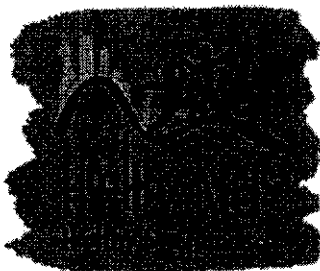
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SAN FRANCISCO UNIFIED SCHOOL DISTRICT

NOTISYA NA MAY KAKULANGAN REKISISYON

Pangalan _____ Grado _____ Kuarto _____ Petsa _____

Ang mga dokumentong pangkalusugan ng inyong anak ay hindi sapat para matugunan ang hinihiling ng Distrito ng San Francisco at batas ng California. Ang mga alituntunin ay pinapaliwanag ng nakakabit ng School Health Form.

NANGANGAILANGAN ANG INYONG ANAK NG:

- | | |
|---|---|
| <input type="checkbox"/> Polyo # _____ | <input type="checkbox"/> Eksaminasyong Pisikal |
| <input type="checkbox"/> DTaP/DT/Td# _____ | <input type="checkbox"/> Pinakahuliing TB Test at resulta |
| <input type="checkbox"/> Tigdas, Baike at Rubela _____ (MMR) | <input type="checkbox"/> Prueba ng pag-gamot o preskripsyon ng positibong (TB test) |
| <input type="checkbox"/> Hepatitis B _____ (3 dosis) | <input type="checkbox"/> Resulta ng X-Ray (____/____/____) |
| <input type="checkbox"/> Bulutong _____ (Chickenpox) | <input type="checkbox"/> Resulta ng TB test noong (____/____/____) |
| <input type="checkbox"/> Nagkaroon na ng sakit na bulutong (____/____/____) | |
| <input type="checkbox"/> Walang medical na dokumento ang inyong anak sa eskwela. Pakibigay sa sekretarya ng paaralan ang kumpletong rekord sa bakuna; resulta ng TB; prueba ng mga bakuna, at eksaminasyong pisikal kahit na nakapagbigay ka na sa upisina ng distrito sa araw ng pagpapatala sa inyong anak. | |

PAKIGAWA ANG SUMUSUNOD SA LALONG MADALING PANAHOON: Idala ang inyong anak at ang dokumentong ito sa inyong doktor o klinika, o dili kaya sa mga klinikang nasa likod ng dokumentong ito. Pakisoli ng kumpleto sa kalihim o sekretarya ng paaralan ang dokumentong pangkalusugan o prueba na mayroon ng tipan sa doktor, ng sa gayon ay makapasok sa paaralan ang inyong anak.

ANG HINDI PAGTUPAD SA ALINTUNTUNING ITO, ANG INYONG ANAK AY HINDI MAKAKAPASOK SA ESKUELA. PAKISAULI ANG MGA KAILANGANG DOKUMENTO SA PAARALAN SA:

LUNES MARTES MIERKOLES HUEVES BIYERNES ____/____/____

Kung hindi ninyo naiintindihan ang mga rekisisyon o kung may problema sa pagkuha nito, ang health worker o nars ng paaralan ay matutulungan kayo.

PAARALAN

Health Worker/ Nurse

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NATIVE AMERICAN HEALTH CENTER – 160 Capp St 621-8051
Immunizations and PPD by appointment. Sliding scale

NORTHEAST MEDICAL SERVICES – 1620 Stockton St 391-9686
Immunizations and PPD by appointment. Cost based on financial qualifications

OCEAN PARK HEALTH CENTER – 1351 24th Ave 682-1900
Immunizations and PPD for Ocean Park H.C. patients only

POTRERO HILL HEALTH CENTER – 1050 Wisconsin 648-3022
Appointment made through triage nurse. Free

S.F. GENERAL HOSPITAL FAMILY HEALTH CENTER – 995 Potrero 206-5252
Immunizations and PPD by appointment. Cost based on financial qualifications

S.F. GENERAL HOSPITAL PEDIATRICS – 1001 Potrero 206-8376 Immunizations and PPD by appointment. Cost based on financial qualifications

SFUSD SCHOOL HEALTH CENTER – 1515 Quintara 242-2615 Immunizations and PPD with physical exams. No private insurance accepted.

SILVER AVENUE HEALTH CENTER – 1525 Silver Ave 715-0300
Immunizations and PPD by appointment only. Cost based on financial qualifications

SOUTHEAST HEALTH CENTER – 2401 Keith St 671-7000
Immunizations and PPD by appointment only. (Same day or next day)
Cost based on financial qualifications

SOUTH OF MARKET HEALTH CENTER – 551 Minna St. 626-2951 Pediatric services by appointment Mon, Weds, Thurs 9-11 am. Cost based on financial qualifications

ST. ANTHONY'S CLINIC – 105 Golden Gate 241-8320
Immunizations and PPD by appointment. Registration required. Free

*Same day appointment



San Francisco Unified School District
 School Health Programs Department
 1515 Quintara St.
 San Francisco, CA 94116
 Tel. 415/242-2615
 Fax: 242-2618
 www.sfusd.edu

NOTICE OF EXCLUSION FROM SCHOOL

DATE: _____

STUDENT NAME: _____

SCHOOL: _____ GRADE: _____ ROOM: _____

Dear Parent/Guardian:

The San Francisco Board of Education requires certain health standards.

You were notified several weeks ago that your child needs:

- Polio # _____
- DTaP/DT/ Td (Diphtheria, Pertussis, Tetanus) # _____
- MMR (Measles, Mumps, Rubella) # _____
- Varicella (Chickenpox) _____ Had disease Approximate Date: _____
- Hepatitis B: Dose # _____ of 3
- Physical Exam
- Recent TB Skin test (within one year) and result
- Chest x-ray and proof of treatment of positive TB skin test
- Documented results of TB skin test
- School needs copy of completed immunization/ TB record

The school has not received document(s) confirming the above checked items.

**Starting on (day) _____, (date) _____
 your child will not be able to attend school. We regret taking this action but this policy
 protects your child and others from serious diseases and health problems.**

Your child may return to school as soon as you present a document signed by a health provider that the above items have been provided. If any of the above services are against your physician's advice, please have the medical provider write a note to the school. If the above services are against your religion or personal beliefs, please sign a form at the school.

 Principal

**PUBLIC HEALTH CLINICS AND LOW COST/FREE CLINICS FOR IMMUNIZATION
& TUBERCULOSIS TESTS (PPD)– May 2006
CLÍNICAS DE SALUD PÚBLICAS Y CLÍNICAS GRATIS O PRECIO BAJO
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CASTRO MISSION HEALTH CENTER – 3850 17TH St 487-7500
Call by 1:00 pm for appointment for next day. Cost based on financial qualifications

CHINATOWN HEALTH CENTER – 1490 Mason Ave 364-7600
Immunizations and PPD by appointment. Cost based on financial qualifications

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Immunizations and PPD by appointment. Sliding scale

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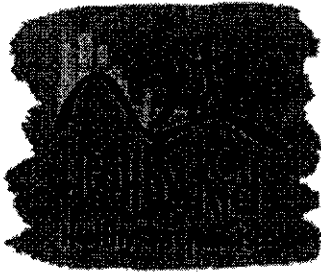
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NOTICIA DE EXCLUSION DE LA ESCUELA

FECHA: _____

NOMBRE DEL ESTUDIANTE: _____

ESCUELA: _____ GRADO: _____ SALÓN: _____

Estimado Padre o Guardián:

El Departamento de Educación Pública del Estado de California requiere de algunas regulaciones de Salud.

Ústed fue notificado/a semanas anteriores que su hijo/a necesita:

- Poliomelitis (Polio/OPV) # _____
- Difteria, Tosferina, Tétanos (DTaP/DT/ Td)# _____
- Sarampión, Rubeola (Sarampión Alemán), Paperas (MMR) # _____
- Varicela (Chickenpox) _____ Ha tenido o/ha sido expuesto a la varicela
 Fecha Aproximada: _____
- Hepatitis B Dosis # _____ de 3
- Examen Físico con la firma del médico y fecha
- Reciente exámen de tuberculosis (aplicado en el mismo año) y el resultado
- Radiografía del pecho y comprobante del tratamiento para TB positiva
- Resultado de la prueba de Tuberculina de la fecha ____/____/____
- La escuela necesita copia completa de Inmunizaciones, Record de Tuberculosis y Exámen Físico

La escuela aún no ha recibido documentos que confirmen la información marcada arriba

A partir de la fecha: _____ Su Hijo/a no podrá asistir a la escuela. Nos molesta tener que tomar esta desición pero esta poliza protege a su hijo/a y a otros contra enfermedades fatales y serios problemas de salud.

Su niño(a) podrá regresar a la escuela en cuanto presente el documento firmado por el médico o clínica de salud con los servicios marcados arriba. Si en alguno de los servicios su médico no está conforme, pidale que escriba una nota dirigida a la escuela. Si los servicios mencionados están en contra de su religión o creencia, por favor firme una forma en la escuela.

 Director/a

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學生停學通知信

日期： _____

學生姓名： _____

學校： _____ 年級： _____ 課室： _____

貴家長/監護人：

三藩市教育局定下一般保健標準：

在幾個星期以前，我們通知貴子弟需要下列之要求：

- _____ 小兒麻痺症防疫第 _____ 次。(IPV/POLIO)
- _____ 白喉，百日咳，破傷風第 _____ 次。(DTaP/DT/Td)
- _____ 麻疹，腮腺炎，德國麻疹防疫第 _____ 次。(MMR)
- _____ 水痘防疫第 _____ 次(VARICELLA)如果已經出過水痘，請將日期寫上 _____
- _____ 乙型肝炎防疫第 _____ 次。(HEPB)
- _____ 體格檢查。(P.E.)
- _____ 近期肺結核檢驗(一年之內)和結果。(TB RESULT)
- _____ 因肺結核檢驗呈陽性反應而需要照肺和治療的證明。(PROOF OF TREATMENT)
- _____ 肺結核檢驗結果報告。(TB TEST RESULT)
- _____ 學校需要一份完整的防疫記錄和肺結核菌檢驗結果報告。(RECORDS NEEDED)

到目前學校尚未收到證件證實上列各項已經完成

由 _____ 月(MONTH) _____ 日(DATE)，星期(WEEK) _____ 開始
貴子弟將不準到學校上課。我們抱歉要採取這行動，但是這政策是要保護
貴子弟和其他學生避免有嚴重或致命的疾病發生。

如你呈交醫務人員簽名之證件以證明上列各項已經完成，貴子弟可以儘早返回
學校上課。假如上列各項是與你的醫生有不同意見，請醫生寫信通知學校。
如以上的要求與你的宗教信仰有矛盾，請到學校簽一份放棄防疫注射表格。

如有疑問，請致電學校保健人員或教育局衛生部門。電話(415)242-2615
內線 3239 保健人員 _____

校長

**PUBLIC HEALTH CLINICS AND LOW COST/FREE CLINICS FOR IMMUNIZATION
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Immunizations and PPD by appointment. Sliding scale

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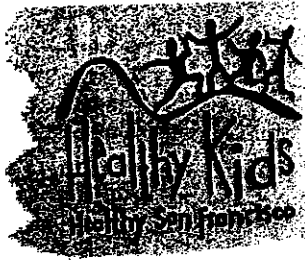
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*Same day appointment



ИЗВЕЩЕНИЕ ОБ ИСКЛЮЧЕНИИ ИЗ ШКОЛЫ (Notice of Exclusion from School)

Дата: _____

Имя _____ Дата рождения _____

Школа _____ Класс _____ Комната _____

Уважаемые родители/опекуны:

Администрация школ г. Сан-Франциско требует выполнения определённых норм здравоохранения.

Уже прошло несколько недель с тех пор, как Вам сообщили, что Вашему ребёнку необходимо предъявить подтверждение о выполнении следующих требований:

Иммунизации и прививки:

- Полиомилит (Polio) № _____
- Дифтерия, коклюш, столбняк (DTaP/DT/Td) № _____
- Свинка, корь, краснуха (MMR) № _____
- Ветрянка (Chickenpox) _____ Переболел
- Гепатит Б (Hepatitis B) Прививка № _____ из 3х необходимых

Другие сведения:

- Полный медицинский осмотр;
- Дата последней проверки на туберкулёз (не более года тому назад) и её результаты;
- В случае положительных результатов проверки на туберкулёз – копии рентгена лёгких и свидетельство о прохождении курса лечения;
- Повторная проверка на туберкулёз и её результаты;
- Необходимо предоставить администрации школы копии всех данных по иммунизации/прививкам и результатов проверок на туберкулёз;

В школу не поступили данные и документация о Вашем ребёнке, подтверждающая выполнение вышеуказанных требований.

Начиная с (День) _____ (Дата) _____

Вашему ребёнку запрещается посещать школу. Мы очень сожалеем о принятии этих мер, но это продиктовано необходимостью ограждения Вашего ребёнка и других детей от серьёзных заболеваний и других проблем, связанных со здоровьем.

Ваш ребёнок сможет вернуться в школу немедленно после представления нам документа за подписью представителя медицинской службы, подтверждающего выполнение вышеуказанных требований. Если Ваш врач не рекомендует соблюдение вышеуказанных требований, пожалуйста, попросите его выдать Вам справку для школы, подтверждающую эту рекомендацию. Если вышеуказанные требования противоречат Вашим религиозным или иным личным убеждениям, просим Вас подписать соответствующий документ, имеющийся в школе.

Если у Вас будут вопросы или Вы нуждаетесь в совете, пожалуйста, обращайтесь к школьному представителю здравоохранения по телефону: (415) 242-2615 доб. 3239 _____
Мед. Работник

Директор Школы

**PUBLIC HEALTH CLINICS AND LOW COST/FREE CLINICS FOR IMMUNIZATION
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San Francisco Unified School District

School Health Programs Department

1515 Quintara Street

San Francisco, CA 94116

TEL 415-242-2615

FAX 415-242-2618

www.sfusd.edu/health/shpd.html

GIẤY BÁO KHÔNG CHO CON EM ĐẾN TRƯỜNG

NGÀY: _____

TÊN HỌC SINH: _____ NGÀY SANH: _____

TÊN TRƯỜNG: _____ LỚP: _____ PHÒNG SỐ: _____

Kính thưa Quý vị Phụ huynh học sinh/Người giám hộ:

Bộ Giáo Dục San Francisco đòi hỏi những tiêu chuẩn sức khỏe nhất định.

Vài tuần về trước, Quý vị được thông báo con em quý vị cần:

- Chích ngừa Bệnh Tê Liệt liều số _____ (Polio # _____)
- Chích ngừa Bệnh Yết-Hầu/Ho Gà/Phong Đòn Gánh liều số _____ (DTaP/DT/Td # _____)
- Chích ngừa Bệnh Sởi/Sưng Quai Bị/Phong Chấn liều số _____ (Measles, Mumps, Rubella)
- Chích ngừa Bệnh Thủy-đậu (Varicella hoặc Chickenpox) _____ Có bị bệnh rồi
- Chích ngừa Bệnh Sưng Gan loại B liều số _____ với 3 lần (Hepatitis B Dose # _____ of 3)
- Khám sức khỏe (Physical Exam)
- Khám nghiệm bệnh lao gần nhất (trong vòng một năm) và kết quả (Recent TB test and result)
- Kết quả chụp hình phổi và y chứng về điều trị bệnh lao (Chest X-Ray and proof of treatment)
- Giấy y chứng khám nghiệm bệnh lao (Documented result of TB skin test)
- Nhà trường cần bản sao giấy chứng nhận hoàn tất sự chích ngừa và thử nghiệm về bệnh lao

Hiện nay nhà trường chưa nhận được giấy y chứng của những mục đánh dấu trong những ô vuông kể trên.

Bắt đầu từ thứ _____ (ngày tháng) _____ con em Quý vị sẽ không được nhận đến trường. Chúng tôi rất tiếc phải chấp hành việc này, nhưng chính sách này để bảo vệ con em và những học sinh tránh được bệnh tật chí tử hay là những vấn đề nguy hại đến sức khỏe.

Con em Quý vị có thể trở về học ngay sau khi Quý vị trình những giấy chứng nhận của nhân viên y tế cho biết những điều ghi trên được thực hiện. Nếu một trong những điều ghi trên trái với lời khuyên răn của bác sĩ, xin yêu cầu bác sĩ viết thư báo cho trường. Nếu những điều trên trái với tín ngưỡng tôn giáo của Quý vị, thì xin vui lòng ký một mẫu đơn tại nhà trường.

Nếu có gì thắc mắc hay quan tâm, xin liên lạc với nhân viên sức khỏe trường học của con em học sinh, điện thoại số (415) 242-2615.

Hiệu Trưởng (Principal)

SFUSD-SHPD 06/07 Notice of Exclusion Vietnamese

Nhân Viên Sức Khỏe Trường Học
(School Health Worker)

**NHỮNG PHÒNG Y TẾ SAU ĐÂY NHẬN MEDI-CAL,
CÓ THỂ KHÁM MIỄN PHÍ HOẶC LÀ THU LỆ PHÍ THẤP**

**PUBLIC HEALTH CLINICS AND LOW COST/FREE CLINICS FOR
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NORTHEAST MEDICAL SERVICES – 1620 Stockton St 391-9686

Immunizations and PPD by appointment. Cost based on financial qualifications

OCEAN PARK HEALTH CENTER – 1351 24th Ave 682-1900

Immunizations and PPD for Ocean Park H.C. patients only

POTRERO HILL HEALTH CENTER – 1050 Wisconsin 648-3022

Appointment made through triage nurse. Free

S.F. GENERAL HOSPITAL FAMILY HEALTH CENTER – 995 Potrero 206-5252

Immunizations and PPD by appointment. Cost based on financial qualifications

S.F. GENERAL HOSPITAL PEDIATRICS – 1001 Potrero 206-8376 Immunizations and PPD by appointment. Cost based on financial qualifications

SFUSD SCHOOL HEALTH CENTER – 1515 Quintara 242-2515 Immunizations and PPD with physical exams. No private insurance accepted.

SILVER AVENUE HEALTH CENTER – 1525 Silver Ave 715-0300

Immunizations and PPD by appointment only. Cost based on financial qualifications

SOUTHEAST HEALTH CENTER – 2401 Keith St 671-7000

Immunizations and PPD by appointment only. (Same day or next day)

Cost based on financial qualifications

SOUTH OF MARKET HEALTH CENTER – 551 Minna St. 626-2951 Pediatric services by appointment Mon, Weds, Thurs 9-11 am. Cost based on financial qualifications

ST. ANTHONY'S CLINIC – 105 Golden Gate 241-8320

Immunizations and PPD by appointment. Registration required. Free

*Same day appointment



San Francisco Unified School District
 School Health Programs Department
 1515 Quintara St.
 San Francisco, CA 94116
 Tel. 415/242-2615
 Fax: 242-2618
 www.sfusd.edu

NOTISYA NA HINDI MAKAKAPASOK SA ESKUELA

PETSA: _____

PANGALAN: _____

PAARALAN: _____ GRADO: _____ KUARTO: _____

Mahal Na Magulang/Tagapagalaga:

Ang Lupon ng Edukasyon ng San Francisco ay kinakailangang makatiyak ng mga pangkalusugang pamantayan.

Ipinagbigay-alam sa inyo noong nakaraang linggo na ang inyong anak ay nangangailangan ng:

- Polyo # _____
- Dipteria, Pertusis, Tetanus(DPT/DT/TD) # _____
- Tigdas, baiki, rubella (MMR) _____
- Bulutong (Chickenpox) _____ / Nagkaroon na ng sakit bulutong _____
- Hepatitis B: _____ (3 dosis) _____ (petsa)
- TB Test at resulta (Pinakahuli) _____
- X-Ray o prueba ng paggamot sa positibong TB test
- Eksaminasyong pisikal
- Prueba sa resulta ng TB test
- Ang paaralan ay nangangailangan ng kumpletong kopya ng mga bakuna, TB test na may resulta at eksaminasyong pisikal, ang paaralan ay hindi nakatanggap ng dokumentong katibayaban na nakatala sa itas.

Magmula sa (araw) _____ (petsa) _____ ang inyong anak ay hindi makakapasok sa eskwela. Ikinalulungkot naming ang kilos na ito, bagamat patakarang ito ay upang mapangalagaan any inyong anak at ang ibang bata sa mga nakakamatay at maselang problemang pangkalusugan.

Ang inyong anak ay makakapasok muli sa lalong madaling panahon sa oras na makapagdala siya ng katibayang galing sa doctor na tinupad ang nakamarka sa itaas. Kung ang serbisyong nakatala sa itaas ay hindi sang-ayon sa payo ng inyong doktor, humingi lamang ng sulat sa doktor. Kung salungat sa inyong paniniwala at relihiyon ang mga nasabing serbisyo, pirmahan lamang ang waiver na nasa likod ng blue-card.

Kung kayo ay may katanungan, tumawag lamang kayo sa eskwela ng inyong anak at magusisa sa nars o health worker sa Telepono (415) 242-2615 ekstensyon 3239 _____
 (School Health Worker)

 Punong Guro

 Health Worker/ Nurse

**PUBLIC HEALTH CLINICS AND LOW COST/FREE CLINICS FOR IMMUNIZATION
& TUBERCULOSIS TESTS (PPD)– May 2006
CLÍNICAS DE SALUD PÚBLICAS Y CLÍNICAS GRATIS O PRECIO BAJO
公共衛生局和低收費或免費診所**

CASTRO MISSION HEALTH CENTER – 3850 17TH St 487-7500

Call by 1:00 pm for appointment for next day. Cost based on financial qualifications

CHINATOWN HEALTH CENTER – 1490 Mason Ave 364-7600

Immunizations and PPD by appointment. Cost based on financial qualifications

***MAXINE HALL HEALTH CENTER – 1301 Pierce St 292-1300**

Drop-in for immunizations and PPD, call first as schedule changes weekly. Must be in line by 7:30 am to receive immunizations. Free for children.

MISSION NEIGHBORHOOD HEALTH CENTER – 240 Shotwell 552-3870

Immunizations and PPD for Mission Neighborhood H.C. patients only

NATIVE AMERICAN HEALTH CENTER – 160 Capp St 621-8051

Immunizations and PPD by appointment. Sliding scale

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