

# Required Age and Health Information

## Documentation Required for Students Enrolling in California Public Schools

- **Proof of Age Required to Start School:**
  - Proof of age is **required** for students entering a California public school for the first time.
  - For students beginning this year, state law requires that a child must be 5 years old on or before September 1 for the 2014-2015 school year and beyond. **Verification of their birthday** must be furnished in the form of a certified copy of a birth record, a statement by the Department of Public Health certifying date of birth, a baptismal certificate, a passport, or an affidavit of the parent or guardian
- **Immunization Requirements:**
  - *Guide to Immunizations Required for School Entry* (attached)

**IMPORTANT!!** **ALL** incoming 7th and 8th graders will be required to show proof of a Tdap booster shot before starting school.

- **Health Examination for School Entry:**
  - This required examination may be completed up to 18 months prior to entry into **first grade**. Every effort should be made to have the exam completed by **kindergarten entry** along with the required immunization records. Doctors' offices and clinics are supplied with the appropriate form or you may download the form to take to the doctor.
  - *Health Examination for School Entry* (attached)
- **Oral Health Exam:**
  - *Oral Health Assessment Form* (attached)
- **Exemption to Required Immunization:**
  - This form is required to be taken to a physician for signature.
  - *Personal Beliefs Exemption to Required Immunizations* (attached)

For information about Orange County Health clinics, please go to the following website:

<http://ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=13549> (attached)

# Grades K-12



**INSTRUCTIONS** Use this guide as a quick reference to help you determine whether children seeking admission to your school meet California’s school immunization requirements. For the actual laws, see 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. If you have any questions, call the Immunization Coordinator at your local health department.

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

VACCINE	REQUIRED DOSES
<b>Polio</b>	<b>4 doses at any age, but...</b> 3 doses meet requirement for ages 4–6 years if at least one was given on or after the 4th birthday <sup>1</sup> ; 3 doses meet requirement for ages 7–17 years if at least one was given on or after the 2nd birthday. <sup>1</sup>
<b>Diphtheria, Tetanus, and Pertussis</b>	<b>Age 6 years and under:</b> DTP, DTaP or any combination of DTP or DTaP with DT (diphtheria and tetanus) <b>5 doses at any age, but...</b> 4 doses meet requirements for ages 4–6 years if at least one was on or after the 4th birthday. <sup>1</sup>
	<b>Age 7 years and older:</b> Tdap, Td, or DTP, DTaP or any combination of these <b>4 doses at any age, but...</b> 3 doses meet requirement for ages 7–17 years if at least one was on or after the 2nd birthday. <sup>1</sup> If last dose was given before the 2nd birthday, one more (Tdap) dose is required.
<b>Measles, Mumps, Rubella (MMR)</b>	<b>Kindergarten: 2 doses<sup>2</sup></b> both on or after 1st birthday. <sup>1</sup>
	<b>7th grade: 2 doses<sup>2</sup></b> both on or after 1st birthday. <sup>1</sup>
	<b>Grades 1–6 and 8–12: 1 dose</b> on or after 1st birthday. <sup>1</sup>
<b>Hepatitis B<sup>3</sup></b>	<b>Kindergarten: 3 doses at any age</b>
<b>Varicella</b>	<b>1 dose<sup>4, 6</sup></b>
<b>Tdap Booster</b> (Tetanus, reduced diphtheria, and pertussis)	<b>7th grade: 1 dose</b> on or after 7th birthday. <sup>5, 7</sup>

<sup>1</sup> Receipt of a dose up to (and including) 4 days before the birthday will satisfy the school entry immunization requirement.  
<sup>2</sup> 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.  
<sup>3</sup> Not required for 7th grade.  
<sup>4</sup> Physician-documented varicella (chickenpox) disease history or immunity meets the varicella requirement.  
<sup>5</sup> Tdap, DTaP, or DTP given on or after 7th birthday will meet the requirement. Td does not meet the requirement.  
<sup>6</sup> 2 dose varicella requirement for ages 13-17 years applies to transfer students who were not admitted to a California school before July 1, 2001.  
<sup>7</sup> 8th-12th grade students transferring from outside of California must meet the requirement.

**EXEMPTIONS** The law allows parents/guardians to choose an exemption from immunization requirements based on their personal beliefs or medical conditions. For children with medical exemptions, the physician’s written statement should be submitted. Schools should maintain an up-to-date list of pupils with exemptions, so they can be excluded quickly if an outbreak occurs.

**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.

**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 (Title 17, CCR Section 6035).

## REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

### PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	BIRTH DATE—Month/Day/Year
ADDRESS—Number, Street	City	ZIP code	SCHOOL

### PART II TO BE FILLED OUT BY HEALTH EXAMINER

#### HEALTH EXAMINATION

**NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.**

REQUIRED TESTS/EVALUATIONS	DATE (mm/dd/yy)
Health History	/ /
Physical Examination	/ /
Dental Assessment	/ /
Nutritional Assessment	/ /
Developmental Assessment	/ /
Vision Screening	/ /
Audiometric (hearing) Screening	/ /
TB Risk Assessment and Test, if indicated	/ /
Blood Test (for anemia)	/ /
Urine Test	/ /
Blood Lead Test	/ /
Other	/ /

#### IMMUNIZATION RECORD

**Note to Examiner:** Please give the family a completed or updated yellow California Immunization Record.

**Note to School:** Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
<b>POLIO</b> (OPV or IPV)					
<b>DtaP/DTP/DT/Td</b> (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
<b>MMR</b> (measles, mumps, and rubella)					
<b>HIB MENINGITIS</b> (Haemophilus Influenzae B) (Required for child care/preschool only)					
<b>HEPATITIS B</b>					
<b>VARICELLA</b> (Chickenpox)					
OTHER (e.g., TB Test, if indicated)					
OTHER					

### PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER (optional) and RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

#### RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

- Examination shows no condition of concern to school program activities.
- Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: *(please explain)*

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

- Please check this box if you **do not** want the health examiner to fill out Part III.

\_\_\_\_\_  
Signature of parent or guardian \_\_\_\_\_  
Date

Name, address, and telephone number of health examiner

\_\_\_\_\_  
Signature of health examiner \_\_\_\_\_  
Date

**If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.**

## Oral Health Assessment/Waiver Request Form

California law, *Education Code* Section 49452.8, now requires that your child have an oral health assessment by May 31 in kindergarten or first grade, whichever is his or her first year of public school. The law specifies that the assessment must be performed by a licensed dentist or other licensed or registered dental health professional. Oral health assessments that have happened within the 12 months before your child enters school also meet this requirement. If you cannot take your child for this assessment, you may be excused from this requirement by filling out Section 3 of this form.

### Section 1

#### To be completed by the parent or guardian

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:	Child's race/ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown		

### Section 2

#### Oral Health Data Collection

#### To be completed by the dental professional conducting the assessment

Assessment Date:	<u>Visible caries and/or fillings present:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Visible caries present:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Treatment Urgency:</u> <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended <input type="checkbox"/> Urgent care needed
------------------	---	---	---

***Dental professional's signature***

***Date***

**Return this form to the school by May 31**

*Original to be retained in child's school record.*

**Section 3**  
**Waiver of Oral Health Assessment Requirement**  
**To be completed by a parent or guardian requesting to be excused from this requirement**

I request that my child be excused from the oral health assessment requirement for the following reason: (Please check the box that best describes the reason.)

- I am unable to find a dental office that will take my child's insurance plan.  
My child is covered by the following insurance plan:  
 Medi-Cal/Denti-Cal    Healthy Families    Healthy Kids    None  
 Other \_\_\_\_\_

- I cannot afford an oral health assessment for my child.
- I do not wish my child to receive an oral health assessment.

Optional: other reasons my child could not get an oral health assessment:

---

---

---

California law requires schools to maintain the privacy of students' health information. Your child's identity will not be associated with any report produced as a result of this requirement. If you have any questions about this requirement, please contact your school office.

---

***Signature of parent or guardian***

***Date***

**Return this form to the school by May 31**

*Original to be retained in child's school record.*



# PERSONAL BELIEFS EXEMPTION TO REQUIRED IMMUNIZATIONS



STUDENT NAME (LAST, FIRST, MIDDLE)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE MONTH DAY YEAR ____/____/____	TELEPHONE NUMBER
PARENT/GUARDIAN – NAME		ADDRESS	

## A. AUTHORIZED HEALTH CARE PRACTITIONER LICENSED IN CALIFORNIA – FILL OUT THIS SECTION

I am a (check one):  M.D./D.O.  Nurse Practitioner  Physician Assistant  Naturopathic Doctor  Credentialed School Nurse

**Provision of information:** I have provided the parent or guardian of the student named above, the adult who has assumed responsibility for the care and custody of the student, or the student if an emancipated minor, with information regarding 1) the benefits and risks of immunization and 2) the health risks to the student and to the community of the communicable diseases for which immunization is required in California (immunizations listed in Table below).

\_\_\_\_\_  
Signature of authorized health care practitioner

\_\_\_\_\_  
Date - within 6 months before entry to child care or school

Practitioner name, address, telephone number:

## B. PARENT OR GUARDIAN – FILL OUT THESE SECTIONS

### I. Check one of the boxes below:

- Receipt of information:** I have received information provided by an authorized health care practitioner regarding 1) the benefits and risks of immunization and 2) the health risks to the student named above and to the community of the communicable diseases for which immunization is required in California (immunizations listed in Table below).
- Religious beliefs:** I am a member of a religion which prohibits me from seeking medical advice or treatment from authorized health care practitioners. (Signature of a health care practitioner not required in Part A.)

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date - within 6 months before entry to child care or school

### II. AFFIDAVIT

**Immunizations already received:** I have provided the child care or school with a record of all immunizations the student has received that are required for admission (California Health and Safety Code §120365).

**Immunizations for which exemption is requested:** An unimmunized student and the student’s contacts at school and home are at greater risk of becoming ill with a vaccine-preventable disease. I understand that an unimmunized student may be excluded from attending school or child care during an outbreak of, or after exposure to, any of these diseases for the protection of the student and others (17 CCR §6060). I hereby request exemption of the student named above from the required immunizations checked below because such immunization is contrary to my beliefs.

School Category	Table of Required Immunizations – Check box(es) to request exemption.
Child Care Only	<input type="checkbox"/> <b>Haemophilus influenzae type b</b> (Hib meningitis)
Child Care and K-12 <sup>th</sup> Grade	<input type="checkbox"/> <b>DTaP</b> (Diphtheria, Tetanus, Pertussis [whooping cough]) <input type="checkbox"/> <b>Hepatitis B</b> <input type="checkbox"/> <b>MMR</b> (Measles, Mumps, Rubella) <input type="checkbox"/> <b>Polio</b> <input type="checkbox"/> <b>Varicella</b> (Chickenpox)
7 <sup>th</sup> Grade Advancement (or admission at 7-12 <sup>th</sup> Grade)	<input type="checkbox"/> <b>Tdap</b> (Tetanus, reduced Diphtheria, Pertussis [whooping cough])

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

The California Department of Public Health places strict controls on the gathering and use of personally identifiable data. Personal information is not disclosed, made available, or otherwise used for purposes other than those specified at the time of collection, except with consent or as authorized by law or regulation. The Department’s information management practices are consistent with the Information Practices Act (Civil Code Section 1798 et seq.), the Public Records Act (Government Code Section 6250 et seq.), Government Code Sections 11015.5 and 11019.9, and with other applicable laws pertaining to information privacy.



**Orange County  
Health Care Agency  
Condado De Orange  
Agencia Del Cuidado De Salud**

**Health Referral Line**  
Monday-Friday 8 am- 5pm  
**Línea De Referencia De Salud**  
Lunes a Viernes 8 a.m. a 5 p.m.  
**1-800-564-8448**

For information on free or low cost medical services call the following clinics.  
Para información sobre servicios médicos gratuitos / bajo costo llame a estas clínicas.  
*Services may change without notice / Información sujeta a cambios*

<b>Name &amp; Street address Nombre y Dirección</b>	<b>City Ciudad</b>	<b>Phone Teléfono</b>	<b>Children / Niños</b>	<b>Adults / Adultos</b>	<b>Dental / Dental</b>	<b>Mental Health Salud Mental</b>	<b>Evening/ Sat. Tardes o Sab.</b>
ALTAMED Medical Group Clinics in/Clinicas en: <b>Anaheim, Garden Grove, Huntington Bch, Orange, Santa Ana</b>		877.462.2582	✓	✓			✓
Central City Community Health 2237 West Ball Rd.	<b>Anaheim</b>	714.490.2750	✓	✓		✓	✓
Puente a la Salud Mobile Clinic Clinics in/Clinicas en: <b>Anaheim, Orange, Santa Ana</b>		714.744.8801		✓	✓		
UCI Family Health Centers Clinics in/Clinicas en: <b>Anaheim, Orange, Santa Ana</b>		714.456.7002	✓	✓			
SOS Organization / Share Our Selves 1550 Superior Ave.	<b>Costa Mesa</b>	949.270.2100		✓	✓	✓	
CHOC	<b>Costa Mesa</b>	714.289.4851	✓				
North Orange County Regional Health Center 901 W Orangethorpe Ave.	<b>Fullerton</b>	714.441.0411	✓	✓			✓
Sierra Health Center 1010 S. Brookhurst Rd.	<b>Fullerton</b>	714.870.0550	✓				✓
Sierra Health Center 501 S. Brookhurst Rd.	<b>Fullerton</b>	714.870.0717		✓			
St. Jude Medical 731 S. Highland Ave.	<b>Fullerton</b>	714.446.5100	✓	✓			✓
CHOC	<b>Garden Grove</b>	714.532.7900	✓				
Nhan Hoa Health Care Clinic 7761 Garden Grove Bl	<b>Garden Grove</b>	714.898.8888	✓	✓	✓		✓
VNCOC Asian Health Center 9862 Chapman Ave. Ste B	<b>Garden Grove</b>	714.418.2040	✓	✓	✓	✓	✓
Friends of Family Health Center 501 S. Idaho #190	<b>La Habra</b>	562.690.0400	✓	✓	✓	✓	✓
The Gary Center ( <i>Dental &amp; Mental Health only</i> ) 341 S. Hillcrest St.	<b>La Habra</b>	562.691.3263	✓	✓	✓	✓	
Laguna Beach Community Clinic 362 Third St.	<b>Laguna Beach</b>	949.494.0761	✓	✓	✓	✓	✓
CHOC	<b>Orange</b>	714.532.8361	✓				✓
La Amistad Medical Clinic 353 S. Main St.	<b>Orange</b>	714.771.8006	✓	✓	✓		
Lestonnac Free Clinic 1215 E. Chapman Ave.	<b>Orange</b>	714.633.4600	✓	✓			✓
Camino Health Center 30300 Camino Capistrano	<b>San Juan Capistrano</b>	949.240.2272	✓	✓	✓		✓
CHOC Clinic at Boys & Girls Club	<b>Santa Ana</b>	714.289.4840	✓				
CHOC Clínica Para Niños	<b>Santa Ana</b>	714.289.4800	✓			✓	
Orange County Health Care Agency 1725 W. 17 <sup>th</sup> Street	<b>Santa Ana</b>	800.914.4887	✓	✓	✓		✓
Serve the People Community Health Clinic 1206 E. 17 <sup>th</sup> Street	<b>Santa Ana</b>	714.352.1405	✓	✓			✓
Hurt Family Health center One Hope Dr.	<b>Tustin</b>	714.247.0300	✓	✓		✓	