York Catholic High School

601 E. Springettsbury Avenue, York, PA 17403
717.846.8871 ♣ www.yorkcatholic.org

Immunization Changes for the 2017-18 School Year

June 8, 2017

Dear Parents,

The Commonwealth of Pennsylvania is changing school immunization regulations beginning in August 2017. The regulations are intended to ensure that children attending school in PA are adequately protected against potential outbreaks of vaccine-preventable diseases. A child must have the required medically-appropriate vaccines or a plan to complete those vaccines or risk exclusion from school.

Children in grades 7-12 need the following immunizations for attendance:

- 4 doses of tetanus * (1 dose on or after 4th birthday)
- 4 doses of diphtheria* (1 dose on or after 4th birthday)
- 4 doses of acellular pertussis* (1 dose on or after 4th birthday)
- 4 doses of polio (4th dose on or after 4th birthday and at least 6 months after previous dose given)
- 2 doses of measles, mumps, and rubella (usually given as MMR)
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) or evidence of immunity
- 2 doses meningococcal conjugate vaccine (MCV)
  - 1st dose is given 11-15 years of age; a 2nd dose is required at age 16 or entry into 12th grade.
  - If the dose was given at 16 years of age or older, only one dose is required.
- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap)

* Usually given as DTaP or DTP or DT or Td

Attached is a required Certificate of Immunization form to complete and submit to the York Catholic nurse detailing the dates your child's immunizations were administered. If the form is incomplete based on the state requirements above, a 2nd form (PLAN) must be completed detailing the dates the immunizations are scheduled to be given. The completed Certificate of Immunization (and the PLAN card, if applicable) must be returned to the school nurse by **August 25, 2017**.

Under Pennsylvania state law, students without the Certificate of Immunization form or the PLAN form on file, cannot be admitted school.

If you have any questions, please contact Diane Lupinetti, York Catholic nurse, at 717-846-8871 x221 or dlupinetti@yorkcatholic.org or consult the PA Department of Health website at ***www.dontwaitvaccinate.pa.gov.***

Sincerely,

Katie Seufert

Katie Seufert
Principal

Name ______________________ Birthdate ______________________

Address ______________________ Parent or guardian ______________________

______________________ Telephone ______________________

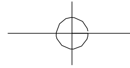
Race/ethnicity: ☐ White ☐ Black ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native

Hispanic origin: ☐ Yes ☐ No

Please circle present grade. K 1 2 3 4 5 6 7 8 9 10 11 12 Other ________

PENNSYLVANIA DEPARTMENT OF HEALTH – CERTIFICATE OF IMMUNIZATION

VACCINE Circle appropriate item	Enter month, day, and year when immunization doses listed below were given.				
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	or Measles serology Date		Titer
Varicella (vaccine or disease)	1 / /	2 / /	Rubella serology Date		Titer
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		



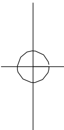
Name ______________________ Birthdate ______________________

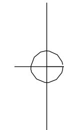
Address ______________________ Parent or guardian ______________________

______________________ Telephone ______________________

Please circle present grade. K 1 2 3 4 5 6 7 8 9 10 11 12 Other ________

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW





MEDICAL EXEMPTION

The physical condition of the above-named child is such that immunization would endanger life or health.

Signed ______________________ Date ______________________
(PHYSICIAN)

RELIGIOUS EXEMPTION

State your reason for requesting this exemption.

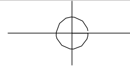
____

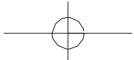
PHILOSOPHICAL/STRONG MORAL OR ETHICAL CONVICTION EXEMPTION

State your reason for requesting this exemption.

____

Signed ______________________
(PARENT OR GUARDIAN) (Date)





PENNSYLVANIA DEPARTMENT OF HEALTH – MEDICAL CERTIFICATE

Name ______________________ Birthdate ______________________

Address ______________________ Parent or Guardian ______________________

______________________ Telephone ______________________

Please circle present grade: K 1 2 3 4 5 6 7 8 9 10 11 12 Other ________

VACCINE Circle appropriate item	Enter month, day and year each immunization **will be given** DOSES				
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	or measles serology Date		Titer
Varicella	1 / /	2 / /	Rubella serology Date		Titer
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		

Attach EHR of vaccines already given.

X____

Signature (PLEASE CIRCLE - physician, certified registered nurse practitioner, physician assistant, local health department)

DIAN