

K - 6th Required Immunization Checklist 2019-2020

Date _____ Student Legal Name _____ Grade (2019-2020) _____
(Last Name) (First Name)
 (contact) _____ (cell #1) _____ (cell #2) _____ (email) _____

Student attended school 2018-19:

In CISD	In Texas	Out-of-State
---------	----------	--------------

If applicable, name of any Conroe ISD school your child has ever attended in the past: _____

To Meet Texas Requirements for Public School Enrollment:

We must have documentation that the following immunizations have been administered prior to enrolling your child.
Please enter the dates that your child had each vaccine and return this form with a copy of your child's vaccination records.

Student's Date of Birth _____ Date of 1st Birthday _____ 4th Birthday _____
(month/day/year) (month/day/year) (month/day/year)

Write or type the dates in the blanks provided.

Complete

	<p>DTaP # 1 _____ 2 _____ 3 _____ 4 _____ 5 _____</p> <p>5 doses of DTaP - 1 dose must be received on or after the 4th birthday. ** 4 doses meet the requirement if 1 dose was received on or after the 4th birthday. **For students aged 7 years or older, 3 doses meet the requirement if 1 dose was received on or after the 4th birthday (dose given up to 4 days before 4th birthday is acceptable) <i>(Also called DTaP, Kinrix, Pediarix, Daptacel, or Pentacel)</i></p>
	<p>Polio (IPV/OPV) # 1 _____ 2 _____ 3 _____ 4 _____</p> <p>4 doses of Polio; 1 dose must be received on or after the 4th birthday. **3 doses meet the requirement if 1 dose was received on or after the 4th birthday (dose given up to 4 days before 4th birthday is acceptable) <i>(Also called IPV, OPV, Kinrix, Pediarix, or Pentacel)</i></p>
	<p>MMR # 1 _____ 2 _____</p> <p>Both doses must have been received on or after the 1st birthday (up to 4 days before 1st birthday is acceptable) <i>(Also called MMR or MMRV)</i></p>
	<p>Varicella # 1 _____ 2 _____ or had Chicken Pox disease _____ <small>(month/year)</small></p> <p>Both doses must have been received on or after the 1st birthday (up to 4 days before 1st birthday is acceptable) <i>(Also called Varivax or MMRV)</i></p>
	<p>Hepatitis B* # 1 _____ 2 _____ 3 _____</p> <p>3 doses of Hepatitis B <i>(Also called Hepatitis B, Pediarix, Comvax, or HBV)</i></p> <p style="text-align: right;">* Hepatitis B is NOT the same as HIB (haemophilus influenzae B)</p>
	<p>Hepatitis A # 1 _____ 2 _____</p> <p>Both doses must have been received on or after the 1st birthday (up to 4 days before 1st birthday is acceptable) <i>(Also called Hep A or HAV)</i></p>

Please email this **COMPLETED** form **WITH A COPY** of the immunization record to the school nurse at _____.
 Immunization records will be periodically reviewed when the nurse is off June 1 - August 5, 2019. The nurse returns to campus on August 6, 2019.