

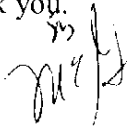
Dear Parents,

Some of you have or will receive letters regarding your child's immunization. We know that some parents were not aware of the new immunization requirements for the current school year.

If you do not receive a letter that means that your child's health record is complete for the current school year. If you do receive a letter, please provide our school nurse with the requested information. Failure to do so will result in your child being excluded from school until the information is received.

You can fax the requested documents to her directly at 301-780-2114. If you have any questions about the letter, please contact our school nurse, Shelley Barnes, RN, C at 301-780-2100 ext. 2010.

Thank you.

A handwritten signature in black ink, appearing to read "Shelley Barnes", is written below the text "Thank you.".



IMMUNIZATION EXCLUSION LETTER

Date _____

Dear Parents or Guardians of _____ Grade _____

According to your child's immunization (shot) records, he/she must receive the immunizations as listed below in order to remain in school. Your child's immunization record and the immunization requirements for his/her age attached. Take these forms with you to your doctor. Have the doctor complete the form below and return it to the school.

Your child will be excluded from school effective _____ unless these immunization records are updated.

Sincerely,

 Principal

Vaccine	Doses child has	Doses child needs	Date vaccine administered
DTP/DTaP/DT/Td			
Polio			
Measles Mumps Rubella (MMR)*			
Varicella**			
Hepatitis B			
Hib***			

Please Note:

- * All doses of Measles, Rubella and Mumps vaccines must be give on or after the first birthday. A blood test indicating proof of immunity and the date performed may be used instead of vaccination for Measles.
- ** Varicella vaccine must be given on or after the first birthday. **Physician documented** history of chickenpox is acceptable in lieu of vaccine.
- *** At least 1 dose of the Hib must be given on or after the first birthday.

Medical contraindications and/or religious exemptions must be submitted on the Maryland Immunization Certificate, DHMH 896.

Indicate the day, month and year of each vaccination.

**** If more than one vaccine in a series is needed, then provide proof of the next appointment.

Physician's Signature _____

Physician's Phone Number _____

Date of next appointment**** _____

7540-3453

PS-118 (Revised 2/11/04)

WHITE - Parent/Guardian

YELLOW - Student's Health Folder