



Notice of Exclusion

Immunization Record Needed for School or Child Care Attendance

Note to Health Care Provider: Colorado Statute 6 CCR 1009-2 mandates the establishment of school required immunizations through the authority of the Colorado Board of Health as a requirement for student attendance in Colorado schools. The "required" school immunization schedule includes the vaccines listed in this document and follows the Advisory Committee on Immunization Practices (ACIP) schedule. It is important that health care providers follow the age and interval requirements for ACIP to include the 4 day grace period for age and intervals. For example, an MMR given more than 4 days before the 1st birthday is an invalid dose and will need to be repeated in order for schools to accept that vaccine. Please contact the Colorado Immunization Branch at 303-692-2700 if you have questions about the school required immunization requirements. Thank you.

To the parent/guardian of: _____

Your child listed above does not have an up-to-date Certificate of Immunization on file and cannot attend this school/child care until a completed immunization record is received (according to Colorado law). The exclusion date will be enforced on: _____. Please contact your health care provider or local county health department at: _____ to obtain the required immunization(s).

The following shot(s) is/are needed:

- | | |
|---|---|
| _____ DTaP (Diphtheria/Tetanus/Pertussis) | _____ Hib (<i>Haemophilus influenzae</i> type b) |
| _____ Tdap (Tetanus/Diphtheria/Pertussis) | _____ PCV13 (Pneumococcal Conjugate) |
| _____ Td (Tetanus/Diphtheria) | _____ Hepatitis B |
| _____ Polio | _____ Varicella * (Chickenpox) |
| _____ MMR (Measles, Mumps, Rubella) | |

* All reporting of Chickenpox disease must be documented by a health care provider (physician or RN).

Please note: If an immunization is against your **religious beliefs**, you must sign a religious exemption. If your child cannot receive an immunization for **medical reasons**, a physician must sign a medical exemption. If you have **personal beliefs** opposed to an immunization, you must sign a personal exemption. Exemption forms can be found on the reverse side of the Colorado Department of Public Health and Environment Certificate of Immunization.

Signed: _____ Date: _____

School or Child Care: _____ Phone: _____ Fax: _____

Method of Notification: _____ Phone _____ Mail _____ In Person

If this box is marked, more than one dose of an immunization noted above is needed and the plan below must be completed by a health care provider. It must also be signed by you and returned by the due date above. As shots are received, submit the record. This plan will be in process until the Certificate of Immunization is completed.

Vaccine	Health Care Provider		Due to Be Received				
	If you need a referral to a health care provider, call 1-800-688-7777		Schedule must follow medically recommended intervals consistent w/ ACIP, AAP, or the vaccine manufacturer's package insert.				
DTaP	Name:	Phone:	Date:	Date:	Date:	Date:	Date:
Tdap	Name:	Phone:	Date:				
Td	Name:	Phone:	Date:	Date:	Date:	Date:	
Polio	Name:	Phone:	Date:	Date:	Date:	Date:	
MMR	Name:	Phone:	Date:	Date:			
Hib	Name:	Phone:	Date:	Date:	Date:	Date:	
PCV13	Name:	Phone:	Date:	Date:	Date:	Date:	
Hepatitis B	Name:	Phone:	Date:	Date:	Date:	Date:	
Varicella	Name:	Phone:	Date:	Date:			

I agree to the above plan for receiving the required shots, submitting the records, and completing the Certificate of Immunization.

Signed: _____ Date: _____
Parent/guardian of the child or emancipated child listed above