



# Zachary Community School District

## Student Registration

### Required Document Checklist

#### **Required Student Documents:**

1. Birth Certificate
2. Social Security Card
3. Immunization Record
4. Current Custody Paperwork signed by a Judge, if applicable
  - a. Provisional Custody by Mandate is not accepted.
5. IEP or IAP, if applicable
6. Previous Report Card, if applicable
7. Withdraw slip from previous school, if applicable
8. LA Student Residency Form

**Zachary Community School District Student Registration** can be found at [www.zacharyschools.org/registration](http://www.zacharyschools.org/registration)

Please have the documents listed on this page completed to upload into the registration system.

#### **Required Residency Documents:**

##### **\*If the parent is the homeowner or lessee:**

1. Mortgage or Lease Agreement/rental contract on company letterhead with the landlord's name and phone number
2. City of Zachary Gas/Water bill, showing name and address (current)
3. Electricity Bill – DEMCO/Entergy (current)
4. Driver's License of Parent (address must match residence address)

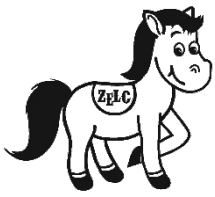
##### **\*If the parent resides with someone (Double Up):**

1. Driver's License of Parent (address must match residence address)
2. Notarized Affidavit of Residency
3. Proof of termination of lease of prior residence as well as proof of termination of utilities **or** bill of sale from prior residence
4. 3 proofs in parent's name (matching the residence address) made up of the following:
  - Paycheck
  - Bank statements: preprinted account statements from your bank. Bank statements printed from a home computer are not accepted.
  - Loan Payment Statements
  - Tax Statements (W2) – Forms can be requested from your employer
  - Voter Registration
  - Vehicle Registration
  - Court Letter
  - Correspondence from any government agency
  - Supervisor of School and Home Relations may accept other pieces of mail addressed to your name at the current residence

*\*Students will be enrolled provisionally pending proofs required under #4. Parents have 30 days from enrollment to obtain and submit 3 proofs of residence to the Supervisor of School and Home Relations.*

#### **AND the following Documentation of the Homeowner/Lessee as follows:**

5. Mortgage or Lease Agreement/rental contract on company letterhead with the landlord's name and phone number
6. Copy of Drivers License of Homeowner/Lessee (address must match residence address)
7. City of Zachary Gas/Water bill, showing name and address (current)
8. Electricity Bill – DEMCO/Entergy (current)



# Zachary Early Learning Center

## Pre-Kindergarten Student Registration

Documents below are required in addition to the documents on Page 1.



### **Required Student Documents:**

\*these are required in addition to the documents on page 1.

1. ZECN Registration Form
2. Benefits Eligibility Form

### **Non-tuition students:**

Families who wish to apply for non-tuition Pre-Kindergarten must provide proof of family income for an application to be considered.

#### **Proof of Income must include at least one of the following:**

- Two (2) current consecutive check stubs for EACH PARENT or CAREGIVER IN THE HOUSEHOLD.
- An official letter from your employer stating all of the following
  - Where parent/guardian is employed
  - Hourly rate of pay
  - The average number of hour(s) parent/guardian works per week.
- SNAP Card/Food Stamps & case detail sheet: must include the child's name and valid effective dates.
- A statement from the Social Security Administration verifying that the child listed on the application is a recipient of SSI benefits, which must be accompanied by two current check stubs.
- Current foster care placement agreement from DCFS
- Parents who are unemployed must submit a letter of support and income documentation from support source.
- Other income verification proof, etc.

**Pre-Kindergarten** students must be **four** years old by September 30<sup>th</sup>.

Both tuition and non-tuition Pre-Kindergarten spaces are limited and applications will be processed on a first come, first served basis.

Zachary Early Learning Center monthly tuition is \$450.00

- This cost does not include breakfast and lunch.

At time of registration, a non-refundable registration fee of \$50 will apply to all applicants. Payments can be made check, cash, or money order. No debit or credit cards can be accepted. At this point, the registration process is complete.

Further questions can be answered at 654-6011 for PreK students.



# Zachary Early Childhood Network Application

Date of Application: \_\_\_\_\_ Desired Start Date \_\_\_\_\_

Please fill in the form completely and accurately. All information will be kept confidential.

2023-2024

## Student Information

Child's Full Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Gender:  Male  Female Preferred Language: \_\_\_\_\_ Month Day Year

Primary Ethnic: (choose one)	<input type="checkbox"/> 0 White	<input type="checkbox"/> 1 Black	<input type="checkbox"/> 2 Hispanic
	<input type="checkbox"/> 3 Asian	<input type="checkbox"/> 4 Native American/Alaskan Native	<input type="checkbox"/> 5 Hawaiian/Pacific Islander
Secondary Ethnic: (if applicable)	<input type="checkbox"/> 0 White	<input type="checkbox"/> 1 Black	<input type="checkbox"/> 2 Hispanic
	<input type="checkbox"/> 3 Asian	<input type="checkbox"/> 4 Native American/Alaskan Native	<input type="checkbox"/> 5 Hawaiian/Pacific Islander

## Site Preference

Please rank your site preferences 1-11 with 1 being your first choice

- |   |   |   |
|---|---|---|
| ____ Bright Beginnings Child Development Center | ____ Kidz Karousel North                | ____ St. Patrick's Episcopal Day School         |
| ____ Early Steps Learning Center                | ____ Little Dreamers Christian Academy  | ____ Tori's Family Learning Center              |
| ____ Just Like Home Child Care Center Three     | ____ Rising Starz Early Learning Center | ____ Universal Children's Learning Academy, LLC |
|   | ____ Sacred Angels Learning Academy     | ____ Zachary Early Learning Center              |

## Guardian Information

### Father or Legal Guardian 1

Relationship to Student \_\_\_\_\_

Title \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Apt.# \_\_\_\_\_ Apt. Complex \_\_\_\_\_ House# \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Email \_\_\_\_\_

### Mother or Legal Guardian 2

Relationship to Student \_\_\_\_\_

Title \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Apt.# \_\_\_\_\_ Apt. Complex \_\_\_\_\_ House# \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Email \_\_\_\_\_

Please Note: List only the people who are supported by the income of the parents or guardians of the child applying.

Family Size: Determined by including all persons living in the household who are supported by the income of the child's parents or guardians and related to the parents or guardians by blood, marriage or adoption.

\_\_\_\_\_ # of Adults \_\_\_\_\_ # of Children

Are you and your family:  Homeless  Foster Family

Does your child have identified disabilities? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is your child in the Early Steps Program: \_\_\_\_\_ Yes \_\_\_\_\_ No

I certify that this information is true and correct. \_\_\_\_\_ Yes \_\_\_\_\_ No Signature \_\_\_\_\_

I understand that if I deliberately misrepresent my family income or circumstances, my family may not be eligible for further services. In the event my child is not accepted into the program, my application may be released to local child care centers.

\_\_\_\_\_ Yes \_\_\_\_\_ No

\*Proof of income required. See attached sheet

\_\_\_\_\_ I decline submitting income verification. I am responsible for all tuition and fees.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Zachary Early Childhood Network**  
**Proof of Income**



**Proof of Income may include one of the following:**

- \_\_\_\_\_ Two (2) consecutive check stubs for EACH PARENT or CAREGIVER IN THE HOUSEHOLD for current year
  
- \_\_\_\_\_ An official letter from your employer stating all of the following
  - Where parent/guardian is employed
  - Hourly rate of pay
  - The average number of hour(s) parent/guardian works per week.
  
- \_\_\_\_\_ SNAP/Food Stamps- must include the child's name and valid effective dates.
  
- \_\_\_\_\_ A statement from the Social Security Administration verifying that the child listed on the application is a recipient of SSI benefits, which must be accompanied by two current check stubs.
  
- \_\_\_\_\_ Current foster care placement agreement from DCFS
  
- \_\_\_\_\_ Parents who are unemployed must submit a letter of support and income documentation from support source.
  
- \_\_\_\_\_ Other: CCAP, etc.

**Zachary Community Schools**  
School Registration

School	Date
SID#	Teacher
Method of Transportation	Bus #

**Student Information**

Social Security or ID assigned by previous LA District \_\_\_\_\_ Birth Certificate # \_\_\_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Name \_\_\_\_\_ Generation (Jr., III, etc) \_\_\_\_\_

Sex \_\_\_\_\_ Grade \_\_\_\_\_

Primary Ethnic: (choose one)	<input type="checkbox"/> 0 White	<input type="checkbox"/> 1 Black	<input type="checkbox"/> 2 Hispanic
	<input type="checkbox"/> 3 Asian	<input type="checkbox"/> 4 Native American/Alaskan Native	<input type="checkbox"/> 5 Hawaiian/Pacific Islander

Secondary Ethnic: (if applicable)	<input type="checkbox"/> 0 White	<input type="checkbox"/> 1 Black	<input type="checkbox"/> 2 Hispanic
	<input type="checkbox"/> 3 Asian	<input type="checkbox"/> 4 Native American/Alaskan Native	<input type="checkbox"/> 5 Hawaiian/Pacific Islander

Language spoken at home \_\_\_\_\_

Language first acquired by student \_\_\_\_\_

Language most often spoken by student \_\_\_\_\_

Birth Date \_\_\_\_\_ Place of Birth \_\_\_\_\_  
Month Day Year

Date of Entry to U.S. (if not a natural born citizen) \_\_\_\_\_

**Address Information**

Physical Address \_\_\_\_\_

Apt.# \_\_\_\_\_ Apt. Complex \_\_\_\_\_ House# \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone (225) \_\_\_\_\_

Names of Other ZCSB Students  
living at the student's primary residence \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Guardian Information

**Father or Legal Guardian 1** Relationship to Student \_\_\_\_\_  
Title \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Apt.# \_\_\_\_\_ Apt. Complex \_\_\_\_\_ House# \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_  
**Phone**  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
Email \_\_\_\_\_

**Mother or Legal Guardian 2** Relationship to Student \_\_\_\_\_  
Title \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Apt.# \_\_\_\_\_ Apt. Complex \_\_\_\_\_ House# \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_  
**Phone**  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
Email \_\_\_\_\_

## Medical Information

**Emergency Contact 1** Relationship to Student \_\_\_\_\_  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Phone \_\_\_\_\_ Address \_\_\_\_\_  
**Emergency Contact 2** Relationship to Student \_\_\_\_\_  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Phone \_\_\_\_\_ Address \_\_\_\_\_  
Preferred \_\_\_\_\_  
Hospital \_\_\_\_\_ Physician \_\_\_\_\_ Telephone \_\_\_\_\_  
Allergies \_\_\_\_\_ Physical Handicaps \_\_\_\_\_

## Additional Information

Please check any special education services your child has ever received  
 Speech  Special Education  504  Gifted Talented  Other, please list \_\_\_\_\_  
Has this student ever attended school in Zachary Community School System? \_\_\_\_\_  
If yes, where? \_\_\_\_\_  
Elementary aged students: Check all programs attended:  
 Play School  Nursery School  Pre Kindergarten  Kindergarten  Headstart \_\_\_\_\_  
Incoming Kindergarteners: Check all programs attended:  Home (no Pre-K)  Tribal Schools  
 Public School PreK  NonPublic PreK  Licensed Childcare  Head Start Programs  
Please list the schools with the grades the student has attended  
School \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

X

My signature attests to the accuracy of the information given on this form under penalty of law.

(Form Must Be Included In School Enrollment Packet)

Date: \_\_\_\_\_ LEA: \_\_\_\_\_ School Name: \_\_\_\_\_

Student Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Gender: Male / Female

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Last School Attended: \_\_\_\_\_ Current Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent / Guardian / Adult Caring for Student: \_\_\_\_\_ Relationship: \_\_\_\_\_

*Disclaimer: This questionnaire is intended to address the McKinney-Vento Act. Your child may be eligible for additional educational services through Title I Part A, Title I Part C Migrant, Individuals with Disabilities Education Act (IDEA) and/or Title IX, Part A, Federal McKinney-Vento Assistance Act, 42 U.S.C.11435. Eligibility can be determined by completing this questionnaire. It is illegal to knowingly make false statements on this form. If eligible, students are to be immediately enrolled in accordance with Bulletin 741, section 341.*

1.  YES  NO Is the student’s address a temporary living arrangement? (Note: If this is a permanent living arrangement or the family owns or rents their home, sign under item 9 and submit form to school personnel.)
2.  YES  NO Is the temporary living arrangement due to loss of housing or economic hardship?
3.  YES  NO Does the student have a disability or receive any special education-related services? (Check one)
4. Where is the student currently living? (Check all that apply.)

In an emergency/transitional shelter.

Temporarily with another family because we cannot afford or find affordable housing.

With an adult that is not a parent or legal guardian, or alone without an adult.

In a vehicle of any kind, trailer park or campground without running water/electricity, abandoned building or substandard housing.

Emergency Housing (i.e. FEMA Trailer or FEMA Rental Assistance)

In a hotel/motel.  Other specific information: \_\_\_\_\_

5.  YES  NO Does the student exhibit any behaviors that may interfere with his or her academic performance?
6. Would you like assistance with uniforms, student records, school supplies, transportation, other?  
(Describe): \_\_\_\_\_
7.  YES  NO Migrant – Have you moved at any time during the past three (3) years to seek temporary or seasonal work in agriculture (including Poultry processing, dairy, nursery, and timber) or fishing?
8.  YES  NO Does the student have siblings (brothers or sisters)? Note: Use back of page if more space is needed.  
Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_ DOB \_\_\_\_\_  
Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_ DOB \_\_\_\_\_  
Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_ DOB \_\_\_\_\_
9. The undersigned certifies that the information provided above is accurate.

Print Parent/Guardian/Adult Caring for Student’s Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

(Area Code) Phone Number \_\_\_\_\_ Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Print School Contact Name \_\_\_\_\_ Title \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Homeless Liaison Use Only – Check All that Apply:

- Sheltered  Doubled-Up  Unsheltered/FEMA/Substandard  Hotel/Motel Unaccompanied Youth:  YES  NO
- School Use Only:  Free or Reduced Price Meals Form submitted/signed  Copy Placed in Student’s Cumulative Record



3755 Church Street  
Zachary, LA 70791  
225.658.4969  
Fax 225.658.5261  
www.zacharyschools.org

## RESIDENCY AFFIDAVIT

**State of Louisiana**

**Parish of East Baton Rouge**

BEFORE ME, the undersigned notary, personally came and appeared:

\_\_\_\_\_ (Full Name), called "Parent/Guardian," a person of the age of majority whose permanent mailing address is (Legal Custodian of Student):

\_\_\_\_\_ Street Number and Name City State Zip

Who did swear before me, upon his/her oath or affirmation, that he/she executed this Affidavit to formally acknowledge that:

\_\_\_\_\_ (Student's Name) is residing with Parent/Guardian at

\_\_\_\_\_ called "Residence Address."  
Street Number and Name City State Zip

Parent/Guardian further deposes and testifies that:

1. Parent/Guardian has been advised and is aware that this Affidavit is being provided to officials of the Zachary Community School Board for purposes of admitting a student(s) to the Zachary Community School System.
2. Parent/Guardian is advised and is aware that the making of intentionally false statements on this Affidavit may expose him/her and the residency owner being charged with filing false public records in violation of **L.A.R.S. 14:133** or other applicable laws of the State of Louisiana.
3. Parent/Guardian is advised that falsification of the information provided will result in the dismissal of the student from the Zachary Community School System.
4. With the foregoing understanding and awareness of the consequences of giving false information and filing false public records, Parent/Guardian attests that:
  - a. The above name student(s) has/have no other residence/domicile in the State of Louisiana other than the Residence Address shown on this Affidavit.
  - b. Parent/Guardian is the parent/legal guardian of \_\_\_\_\_ (Student's Name), who is





3755 Church Street  
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www.zacharyschools.org

residing with \_\_\_\_\_ (Name of Homeowner) at the Residence Address. **(Homeowner must be present and sign where indicated that this information is correct.)**

- c. If the Parent/Guardian's Residence Address changes, Parent/Guardian will visit the Zachary Community School Board Office located at 3755 Church Street, Zachary, LA 70791 within ten (10) days of the change of residence and complete a registration packet for a change of address and provide required residency documentation.
- d. To enable residency verification, Parent/Guardian consents to an inspection and view of the residence herein identified as the student's residence to ensure that the information of the Affidavit to be true and correct.
- e. All parties have carefully completed and read this Affidavit and attest to the truth of all the information provided.

**This document is valid for one year. It will expire on the last day of the current school year.**

**SIGNATURES:**

**WITNESSES:**

\_\_\_\_\_

\_\_\_\_\_

**PARENT/GUARDIAN**

\_\_\_\_\_

\_\_\_\_\_

**HOMEOWNER**

**SWORN TO AND SUBSCRIBED** before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
**NOTARY PUBLIC**

**NOTARY ID#** \_\_\_\_\_

# ZACHARY COMMUNITY SCHOOLS BUS SERVICE REQUEST

*Complete One Per Student*  
**2023 – 2024 School Year**

Student's Name: \_\_\_\_\_.

I, (parent/guardian's name) \_\_\_\_\_, DO ( ) \*\* DO NOT( ) want bus service for my child for the **2023-24** school year. If you **DO NOT** want bus service for your child, please enter your name and your child's name on the lines above, sign on the signature line below\*, and return this form to your child's school. If you **DO WANT** bus service for your child, please enter **ALL** requested information on this form and return to your child's school **immediately**. If a child does not need transportation in the morning or evening because of car pooling or other arrangements, please indicate so by writing "no ride" in the morning or evening box.

\_\_\_\_\_  
 Parent/Guardian Signature\* Sign Here

\_\_\_\_\_  
 Today's Date

Student's School for 2023 - 2024: \_\_\_\_\_ Student's Grade for 2023-2024: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Physical Home Address (No P.O. Boxes): \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

**ENTIRE PHYSICAL ADDRESS WHERE CHILD WILL BE PICKED UP IN THE MORNING (NO P.O BOXES):**



**ENTIRE PHYSICAL ADDRESS WHERE CHILD WILL BE DROPPED OFF IN THE EVENING (NO P.O. BOXES):**



If No Ride in AM or PM please place "No Ride" on appropriate Line. No response means student will be dropped at same location as picked up.

Home Phone Number: \_\_\_\_\_

Work Phone Number of Mother: \_\_\_\_\_ Cell #: \_\_\_\_\_

Work Phone Number of Father: \_\_\_\_\_ Cell#: \_\_\_\_\_

Other Emergency Names and Phone Numbers: \_\_\_\_\_

If your child receives Special Education services, does your child's I.E.P. indicate special transportation services be provided?  Yes  NO

Does your child require a 5-point harness while riding the bus?  Yes  No

Thanks in Advance for your assistance. Please Allow 2-3 Business Days

Principals Approval \_\_\_\_\_ Date \_\_\_\_\_

Upon completion of this form please submit it to your child's school in hand or by email.

**TO BE FILLED OUT BY FIRST STUDENT OFFICE ONLY**

Bus # _____	Stop Location _____	P/U Time _____	
Bus # _____	Stop Location _____	D/O Time _____	

# ZACHARY COMMUNITY SCHOOL BOARD

## Parental Authorization to Publish Student Names, Videos, Photos, or Work

Dear Parent,

Your child's art, writing, video or picture may be considered for publication on the Zachary Community School Board website or other media outlets. The website is located on the Internet at **<http://www.zacharyschools.org>**. Please complete and return the following consent form. Forms will be filed at the school location.

The following information is considered private and will not be placed in any publication, except where described below.

Today's Date \_\_\_\_\_

School Year \_\_\_\_\_

Student's Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City, State, and Zipcode \_\_\_\_\_

Home Phone \_\_\_\_\_

Age \_\_\_\_\_

Grade \_\_\_\_\_

Teacher's Name \_\_\_\_\_

School \_\_\_\_\_

I give permission for my child's writing, picture, video or art, first name and last name initial, age, grade, and school's name to be published on the Zachary Community School Board website at <http://www.zacharyschools.org> or in other media outlets.

Parent's Signature \_\_\_\_\_

Teacher's Signature \_\_\_\_\_

I have written this composition myself. This work of art is my own original work.

Student's Signature \_\_\_\_\_



## Zachary Community Schools School Nurse Department

Welcome to Zachary Community Schools. We are excited that you have chosen our school system, which is one of the fastest growing, top-rated districts in the state, to educate your child.

In order to provide the best care possible for your child while at school, it is important for us to be aware of any medical conditions that might affect them during school hours or any condition that requires medication or possible nursing assistance (e.g. asthma, seizure disorder, diabetes, severe allergies, etc.). If your child does not have any medical issues or does not require any medication at school, we only need your signature on the "HIPPA Policy" form to be returned to school.

If your child has special medical needs, please complete and sign the enclosed forms. In addition, if your child requires medication at school, you may pick up the state mandated medication packet at your child's school or you may download these forms from the district website ([www.zacharyschools.org](http://www.zacharyschools.org)) Go to top of the page to Departments>Academics>Student Support Services>School Nurses. Find the Medication packet on the left-hand side of the screen. Complete the form and return to your child's school. A parent will have to bring the medication to school to be checked and logged in. **Please note that medication of any kind, including over-the-counter medication, may NEVER be sent to school with your child and MUST be checked in by a parent along with the medication packet completed.**

Also, please ensure that your child's immunizations are up-to-date, and that his/her school has an updated copy. This is required by Louisiana Department of Health and Hospitals and must be on file for your child to attend school.

Thank you in advance for your cooperation. We look forward to caring for your child.

Zachary Community School District School Nurses

# HIPAA POLICY

## NOTICE OF USE OF PERSONAL HEALTH INFORMATION

This notice describes how medical information about your child may be used and disclosed and how you can get access to this information. Please review it carefully:

We understand that any information we collect about your child and their health is personal. Keeping your child's health information private is one of our most important responsibilities. We are committed to protecting their health information and following all laws about its use. You have the right to discuss your concerns with the system's Privacy Officer about how their health information is shared. The law says:

1. We must keep student's health information from others who do not need it.
2. You may ask us not to share certain health services information with others. However, occasionally certain situations prohibit us from complying with a request as such.

Your child may receive certain services from nurses, therapists, social workers, doctors, or other health-care related individuals. They may see, use, and share your child's health or medical information to determine any plan of treatment, diagnosis, or outcome of the said information as described in an Individualized Education Program (IEP) or other plan document. This use may cover such health services your child had before now or may have later.

We review such health services information and claims to make sure that you get quality services and that all laws regarding providing and paying for such health services are followed. We may also use the information to remind you about services or to inform you about treatment alternatives. In addition, we may also use the information to obtain payments for such services as a result of the Medicaid program. We must submit information that identifies you and your child, your child's diagnosis, and the type of services provided to your child for reimbursement by Medicaid.

We may share your health care information with teachers through health plans, with insurance companies and/or government programs in order for our school system to be reimbursed for such health care or medical services rendered during the school day.

As a general rule, you may request to see your child's health information. However, the request may not include psychotherapy notes or information being gathered for judicial proceedings. There may be legal reasons or safety concerns that would limit the amount of information that you may see. You may ask in writing to receive a copy of your child's health information. We may ask for payment for copying costs.

If you suspect some of your child's health information is wrong, you may ask in writing that we correct or amend it and you must provide the appropriate documentation, if applicable, from your child's physician in order to verify it.

You may request in the form of a signed 'Authorization of Release of Information' that any health information be sent to others who have received your child's health information previously from us. In addition, you may also request a comprehensive list of any recipients of such information. At any time, you may stop or limit the amount of information being shared by informing us in writing.

Note: A child 18-years old or older can give consent for his or her health information to be shared by signing an 'Authorization of Release of Information'.

In certain situations, we are mandated to abide by laws pertaining to sharing particular health information regarding your child, even if an 'Authorization of Release of Information' is not signed. We always report:

1. Contagious diseases, birth defects, and cancer;
2. Firearm injuries and other trauma events;
3. Reactions to problems with medicines or defective medical equipment;
4. To the police or other governmental agencies when required by law;
5. When a court orders us;
6. To the government to review how our programs are working;
7. To Worker's Compensation for work related injuries;
8. Date of birth and immunization information;
9. Abuse, neglect, and domestic violence, if related to child protection or vulnerable adults; or
10. To parents and other designated by law.

We may also share health care information for permitted research purposes and for matters concerning serious threats to public health or safety. Furthermore, if the health information falls within the FERPA definition of "education record", it will not be considered private health information under HIPAA, and therefore, will not be regulated by HIPAA.

If you have any questions about this notice of privacy rights or feel that such rights have been violated, you may contact:

Zachary Community School Board Office  
(225) 658-4969 telephone  
3755 Church Street, Zachary, LA 70791

You can also complain to the federal government Secretary of Health and Human Services (HHS) or to the HHS Office of Civil Rights. Your health care services will not be affected by any complaint made to the Zachary Community School Board, Secretary of Health and Human Services, or Office of Civil Rights.

You may ask for additional copies of our HIPAA policy at any time. The following link provides additional information regarding HIPAA and FERPA relevant to student health records.

[https://oese.ed.gov/files/2020/10/handout\\_hipaaferpa.pdf](https://oese.ed.gov/files/2020/10/handout_hipaaferpa.pdf)

# ZACHARY COMMUNITY SCHOOL BOARD

Dear Parent,

Attached you will find the Zachary Community School Board HIPAA policy Notice of Use of Personal Health Information. Please sign and return this form, so that we may maintain a record of your having received the information. Failure to return the signed form may result in a delay in servicing your child.

Thank you,

Zachary Community School Nurses

This is to certify that I have received and read a copy of the "Notice of Use of Personal Health Information".

\_\_\_\_\_  
Parent's Signature

Names of children attending Zachary Community Schools and grades/homeroom teachers of each:

_____ Name	_____ Grade	_____ Homeroom Teacher
_____ Name	_____ Grade	_____ Homeroom Teacher
_____ Name	_____ Grade	_____ Homeroom Teacher
_____ Name	_____ Grade	_____ Homeroom Teacher
_____ Name	_____ Grade	_____ Homeroom Teacher

If you have any questions, please feel free to contact your child's school.

# STATE OF LOUISIANA HEALTH INFORMATION

## TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

**PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed. Use additional sheets, if necessary, for further explanation.**

Student Name: Last	First	M.I.	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	DOB:	Grade:	School:
Student's Mailing Address:			City:	State:	Zip:	
Student's Physical Address:			City:	State:	Zip:	
Name of Mother/Legal Guardian		Home Phone	Work Phone	Cell Phone	Employer	
Name of Father/Legal Guardian		Home Phone	Work Phone	Cell Phone	Employer	
Name of pediatrician/primary care provider		Phone No	Name of medical specialists/clinics		Phone No.	

**Parents: Please notify the school nurse of any changes in the student's medical condition.**

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Please check the type of health insurance your child has:  Private  Medicaid/LaCHIP  None

If your child does not have health insurance, would you like information on no-cost health insurance?  Yes  No

**In case of emergency, if parent or legal guardian cannot be reached, contact the following:**

Name	Phone Number	Cell Phone Number
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My child has a medical, mental, or behavioral condition that may affect his/her school day:  No  Yes

(If yes, please complete Part 2)

**PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD.** Parent/Legal Guardian is responsible for providing the school with any medication and may be responsible for providing the school with any special food or equipment that the student will require during the school day. Check with the school nurse to obtain correct medication and procedure forms. **Parents are responsible to keep the school nurse informed regarding their child's health status.**

**ALLERGIES**

Allergy Type:

Food (list food(s) \_\_\_\_\_)  Medication (list medication(s) \_\_\_\_\_)

Insect sting (list insect(s) \_\_\_\_\_)

Other (list) \_\_\_\_\_

Reactions- Date of last occurrence:

Coughing Date: \_\_\_\_\_  Swelling Date: \_\_\_\_\_  Rash Date: \_\_\_\_\_

Difficulty breathing Date: \_\_\_\_\_  Nausea Date: \_\_\_\_\_  Other \_\_\_\_\_

Hives Date: \_\_\_\_\_  Wheezing Date: \_\_\_\_\_



**Currently prescribed medications and treatments:**

Oral antihistamine (Benadryl, etc.)     Epi-pen     Other \_\_\_\_\_

**ASTHMA**

Triggers (i.e., tobacco, dust, pets, pollen, etc.) (list) \_\_\_\_\_

Does your child experience asthma symptoms with exercise?     No     Yes

Symptoms:     Chest tightness, discomfort, or pain     Difficulty breathing     Coughing     Wheezing

Other \_\_\_\_\_

**Currently prescribed medications and treatments:** \_\_\_\_\_

Date of last hospitalization related to asthma \_\_\_\_\_ Date of last ER visit related to asthma \_\_\_\_\_

Does your child have a written asthma management plan?     No     Yes    Is peak flow monitoring used?     No     Yes

**DIABETES**

Currently prescribed medications and treatments:     Insulin     Syringe     Pen     Pump  
 Blood sugar testing     Glucagon     Oral medication(s)    List medication(s) \_\_\_\_\_

Is special scheduling of lunch or Physical Education required?     No     Yes:

**SEIZURE DISORDER**

Type of seizure:     Absence (staring, unresponsive)     Generalized Tonic-Clonic (Grand Mal/Convulsive)

Complex Partial     Other (explain) \_\_\_\_\_

Physical Education Restrictions:     No     Yes

**Medication(s):**     No     Yes    List medication(s) \_\_\_\_\_

Date of last seizure \_\_\_\_\_ Length of seizure \_\_\_\_\_

**OTHER HEALTH CONDITIONS**

**Chicken Pox: Date of disease:** \_\_\_\_\_

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Digestive disorders           | <input type="checkbox"/> Sickle Cell Disease   |
| <input type="checkbox"/> ADD/ADHD        | <input type="checkbox"/> Psychological                 | <input type="checkbox"/> Skin disorders        |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Juvenile Rheumatoid Arthritis | <input type="checkbox"/> Speech problems       |
| <input type="checkbox"/> Cerebral Palsy  | <input type="checkbox"/> Hemophilia                    | <input type="checkbox"/> Other (explain) _____ |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Heart condition               |  |
| <input type="checkbox"/> Depression      | <input type="checkbox"/> Physical disability           |  |

**Physical Education Restrictions:**     No     Yes (explain): \_\_\_\_\_

**Medication(s):**     No     Yes    List medication(s) \_\_\_\_\_

**Special procedures required** (i.e., catheterization, oxygen, gastrostomy care, tracheostomy care, suctioning):     No     Yes (explain): \_\_\_\_\_

- VISION CONDITIONS** \_\_\_\_\_     Contacts/glasses     Other \_\_\_\_\_
- HEARING CONDITIONS** \_\_\_\_\_     Hearing aid(s)     Other: \_\_\_\_\_

**ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION**

**Special adjustments of the school environment or schedule needed?**  No  Yes (explain):  
*(i.e., seizures, limitations in physical activity, periodic breaks for endurance, part-time schedule, building modifications for access)*

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**Special adjustments to classroom or school facilities needed?**  No  Yes (explain)  
*(i.e., temperature control, refrigeration/medication storage, availability of running water)*

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**Special safety considerations required:**  No  Yes (explain):  
*(i.e., precautions in lifting or positioning, transportation emergency plan, safety equipment, techniques for positioning or feeding)*

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**Special assistance with activities of daily living needed:**  No  Yes (explain):  
*(i.e., eating, toileting, walking)*

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**Special diet required?**  No  Yes (explain)  
*(i.e., blended, soft, low salt, low fat, liquid supplement):* \_\_\_\_\_

**Are there anticipated frequent absences or hospitalizations?**  No  Yes (explain):

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**PART 3: SCHOOL NURSE TO REVIEW if parent/legal guardian indicates medical condition.**

**Nurse Notes:** \_\_\_\_\_

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\_\_\_\_\_  
School Nurse Signature

\_\_\_\_\_  
Date

**MEDICAL HISTORY FORM  
ZACHARY COMMUNITY SCHOOLS**

Medical information is needed for the following student in order to determine if there are health impairments sufficient to warrant special education services. This information will also be utilized by the school nurse to provide health services. This form is to be completed by the Doctor. Please check appropriate behaviors and provide a simple explanation when indicated.

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Name of Parent(s)/Guardian:** \_\_\_\_\_

**Current Diagnosis, Medical Status, and Current Medication:** \_\_\_\_\_  
\_\_\_\_\_

**Date Last Seen:** \_\_\_\_\_ **Return to Clinic Date:** \_\_\_\_\_

**Severity of Illness:** \_\_\_ Mild \_\_\_ Moderate \_\_\_ Severe

**Condition Causes:**

- temporary or chronic lack of strength
- temporary or chronic lack of vitality
- temporary lack of alertness
- reduced efficiency in school work because of \_\_\_\_\_

**Student is substantially limited in the following major life activity/activities:** \_\_\_ caring for one's self \_\_\_ seeing \_\_\_ working  
\_\_\_ hearing \_\_\_ walking \_\_\_ performing manual tasks \_\_\_ breathing \_\_\_ speaking \_\_\_ learning  
\_\_\_ other major life activity (describe): \_\_\_\_\_

**Recommendations For Student Integration Into The School Setting**

Activity Restrictions/Limitations \_\_\_\_\_

Accommodations \_\_\_\_\_

Nutritional/Dietary \_\_\_\_\_

Special Procedures \_\_\_\_\_

Speech Therapy \_\_\_\_\_

Physical Therapy/ Occupational Therapy/ Adaptive Physical Education \_\_\_\_\_

Please check if you agree to your patient receiving OT/PT (will be considered orders for service for one year from date doctor signed)

- 
- Occupational Therapy
  - Physical Therapy

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Physician's Name:** \_\_\_\_\_

**Physician's Address:** \_\_\_\_\_

**Office #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_



## ZACHARY COMMUNITY SCHOOLS IMMUNIZATION REQUIREMENTS FOR **PRE-K/KINDERGARTEN**

Under State Law (Act no. 771) all students are required to have proof of immunization. We must have an up-to-date copy of your child's immunizations before school starts.

DTaP----- 5 Doses

IPV-----4 Doses

MMR----- 2 Doses

VAR----- 2 Doses or history of having chicken pox

HepB----- 3 Doses

HIB----- 4 Doses

HepA-----2 Doses

### **\*\*\*IMPORTANT\*\*\***

We are required by the Department of Health and Hospitals to use Louisiana Immunization Network for Kids Statewide (LINKS) web application for recording and reporting all student immunizations. Please note, any immunization given too early or out-of-sequence will be identified as invalid by LINKS and will need to be repeated. If your child's physician chooses not to repeat the said dose, documentation from the physician is required by the Department of Health and Hospitals to include in our records.

Please contact your child's school to speak with a school nurse if you have any questions regarding immunizations.

Thank You,  
Zachary Community Schools  
Nursing Department



**LOUISIANA DEPARTMENT OF HEALTH - OFFICE OF PUBLIC HEALTH  
2022 CHILD/ADOLESCENT IMMUNIZATION SCHEDULE AND  
DAYCARE/SCHOOL ENTRY REQUIREMENTS**

(Revised: 12/1/2022)



Depending on the child's age, choose the appropriate set of immunizations. High-risk children may require additional vaccines. Individuals with an altered immune system, due to disease or medication, must be evaluated by a physician prior to vaccination.

RECOMMENDED SCHEDULE FOR IMMUNIZATION, BY AGE	
Age	Vaccinations
At Birth	HepB
2 Months <sup>[1]</sup>	DTaP, Hib, IPV, HepB, PCV, RV
4 Months	DTaP, Hib, IPV, PCV, RV
6 Months	DTaP, Hib, IPV, HepB, PCV, RV, Flu
7 Months	Flu, then annually
12-15 Months	DTaP, Hib, MMR, VAR, PCV, HepA
18-23 Months	HepA
4 years	DTaP, IPV, MMR, VAR
11-12 Years	Tdap, MenACWY, HPV (VAR, MMR, HepA, HepB if needed)
16 Years	MenACWY, provider-patient discussion for MenB (HPV, VAR, MMR, HepA, HepB, if needed)

ACCELERATED SCHEDULE FOR CHILDREN LATE ON VACCINATIONS	
Visit/Age	Vaccinations
Children 4 months through 6 years of age	
1st Visit <sup>[2]</sup>	DTaP, Hib, IPV, HepA, HepB, MMR, VAR, PCV, Flu
2 <sup>nd</sup> Visit (4 weeks after 1st visit)	DTaP, Hib, IPV, HepB, PCV, Flu
3 <sup>rd</sup> Visit (4 weeks after 2nd visit)	DTaP, Hib, PCV
4 <sup>th</sup> Visit (6 months after 3rd visit)	DTaP, Hib, IPV, PCV, HepA, HepB
4 Years of Age or at School Entry	DTaP, IPV, MMR, VAR
Children 7 through 18 years of age	
1st Visit	Tdap, IPV, HepA, HepB, MMR, VAR
2 <sup>nd</sup> Visit (4 weeks after 1st visit)	Td, IPV, HepB, MMR
3 <sup>rd</sup> Visit (6 months after 2nd visit)	Td, IPV, HepA, HepB
11-12 Years	Tdap, MenACWY, HPV (IPV, VAR, MMR, HepB if needed)
16 Years	MenACWY, provider-patient discussion for MenB

[1] DTaP, IPV, HBV, PCV, RV and Hib can be administered as early as 6 weeks of age and simultaneously.

[2] Depending on the child's age, choose the appropriate initial set of immunizations. Sometimes a scheduled dose of vaccine may not be given on time. If this occurs, the dose should be given at the next visit. It is not necessary to restart the series of any vaccine due to extended intervals between doses.

Note 1: The recommendations above and the vaccine guidelines on page 2 are summaries. For more information, visit <https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html>.

Note 2: For detailed information on each vaccine refer to the manufacturer's product insert.

Louisiana Department of Health also recommends **COVID-19 vaccinations** for children ages 6 months and older. For detailed information on dose recommendations visit <https://www.cdc.gov/vaccines/covid-19/downloads/COVID-19-immunization-schedule-ages-6months-older.pdf>

REQUIRED VACCINATIONS FOR ENTRY INTO DAYCARE AND SCHOOLS						
Daycares/Early Learning		Grade K-12 Schools			Post-Secondary Schools	
Vaccinations	Doses	Grades	Vaccinations	Doses	Vaccinations	Doses
Child must be up to date on vaccinations for their age (see recommendations listed above) according to a valid immunization record		Starting at Kindergarten <sup>[1]</sup> and all subsequent grades thereafter	DTaP <sup>[2]</sup>	5	MMR	2
			HepA	2		
			HepB	3		
			IPV <sup>[3]</sup>	4		
			MMR	2		
			VAR	2		
		Starting at 6 <sup>th</sup> grade and all subsequent grades thereafter	Tdap	1	MenACWY	2 doses, or 1 dose if 1 <sup>st</sup> dose administered on or after age 16
	MenACWY	1				
Starting at 11 <sup>th</sup> grade and all subsequent grades thereafter	MenACWY	Second Dose				

[1] Entry requirement exception for students who are 4 years of age when entering kindergarten at start of school year: To attend kindergarten in Louisiana, students must be 5 years old by September 30 each school year. Therefore, there are instances where a student is still 4 years old when entering kindergarten. In these instances, the 4-year-old student may be admitted into kindergarten so long as a parent/guardian presents a record indicating that the student is in progress of receiving the required vaccinations. In these instances, follow-up from school staff must be provided for compliance with the above requirements.

[2] Those students who received their 4<sup>th</sup> dose of DTaP at age 4 or older do not need a 5<sup>th</sup> dose on record.

[3] Those students who received their 3<sup>rd</sup> dose of IPV at age 4 or older do not need a 4<sup>th</sup> dose on record.

Note: Students may participate in school without the required immunizations listed above if a written statement of exemption is presented by a physician, the individual, or the individual's parent/guardian.

COVID-19 - Vaccines for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Vaccination is recommended for children 6 months and older and series and intervals depend on vaccine type.

**DTaP** - DTaP vaccine is recommended to be administered any time after 6 weeks through 6 years of age. The 4<sup>th</sup> dose of DTaP should be given at least 6 months after the 3<sup>rd</sup> dose. Pediatric DT (Diphtheria-Tetanus) should be substituted for DTaP when Pertussis vaccine is contraindicated. Persons aged 7 and older who are fully immunized with DTaP should receive a Tdap at 11-12 years in place of Td booster.

**Td/Tdap** - Persons aged 7 years and older who are not fully immunized with DTaP vaccine should receive Tdap vaccine as 1 (preferably the first) dose in the catch-up series; if additional doses are needed, use Td vaccine. For children 7 through 10 years who receive a dose of Tdap as part of the catch-up series, an adolescent Tdap vaccine dose should be administered at age 11 through 12 years. Td should be administered instead 10 years after the Tdap dose. Adolescents 13-18 years who missed the 11-12 year Td/Tdap booster should also receive a single dose of Tdap if they completed the recommended childhood DTaP series. No minimum interval required between giving doses of Td and Tdap. Subsequent routine Td boosters are recommended every 10 years. If a Tdap dose is administered at age 10 or older, the Tdap dose may count as the adolescent dose.

Flu - Routine annual influenza vaccination is recommended for all children 6 months-18 years. 2 doses administered at least 1 month apart are recommended for children aged 6 months-8 years who are receiving the influenza vaccine for the 1<sup>st</sup> time. Children 6 months through 8 years getting vaccinated for the 1<sup>st</sup> time, and those who have only previously gotten 1 dose of vaccine, should get 2 doses of vaccine. All children who have previously gotten 2 doses of vaccine (at any time) only need 1 dose of vaccine each season.

**HepA** – Routine Hepatitis A vaccination is recommended for all children 12 months through 18 years of age. The 2 doses in the series should be administered at least 6 months apart. If the interval between the 1<sup>st</sup> and 2<sup>nd</sup> doses of Hepatitis A vaccine extends beyond 18 months, it is not necessary to repeat a dose.

**HepB** - Unimmunized infants should be given a 1<sup>st</sup> dose of Thimerosal-free HBV at the birthing hospital before discharge or when first encountered, a 2<sup>nd</sup> dose a minimum of 1 month later, and a 3<sup>rd</sup> dose a minimum of 4 months after the 1<sup>st</sup>. Children aged 11-18 years of age who have not previously received 3 doses of Hepatitis B vaccine should be vaccinated. The 2<sup>nd</sup> dose should be administered at least 1 month after the 1<sup>st</sup> dose, and the 3<sup>rd</sup> dose should be administered at least 4 months after the 1<sup>st</sup> dose and at least 2 months after the 2<sup>nd</sup> dose. The minimum age for the 3<sup>rd</sup> dose is 6 months. Hepatitis B vaccine is routinely recommended for all children up to 19 years of age.

Hib - Hib vaccine can be administered any time DTaP vaccine is given. If PRP-OMP (PedvaxHIB [Merck]) is administered at 2 and 4 months of age, a dose at 6 months is not required. Children who are 7 months of age or older at the time they receive the 1<sup>st</sup> Hib vaccination should be immunized as follows: (1) Unimmunized infants 7-11 months of age should receive a 3-dose regimen. A 1<sup>st</sup> dose should be given now, a 2<sup>nd</sup> dose 1 month later, and a 3<sup>rd</sup> dose after 12 months of age, at least 2 months after the previous dose. (2) Unimmunized children 12-13 months of age should receive a primary series of 1 dose and a booster at age 15 months. (3) Unimmunized children 15 months of age or older who have not yet reached their 5<sup>th</sup> birthday should receive 1 dose.

HPV – HPV vaccine is a 2-dose series for ages 9-14 years and a 3-dose series for ages 15-26 years. Administer the 1<sup>st</sup> dose of HPV vaccine between 11-12 years. Administer the 2<sup>nd</sup> dose 6-12 months after the 1<sup>st</sup> dose. If the series was started at 15-26 years, then a 3-dose series is required: 4-week minimum interval between dose 1 and dose 2. A minimum interval of 12 weeks required between dose 2 and dose 3. The 3<sup>rd</sup> dose should be given at least 24 weeks after the 1<sup>st</sup> dose. Adolescents aged 9-14 years with 2 doses of HPV vaccine less than 5 months apart, require a 3<sup>rd</sup> dose.

**IPV** - For infants, children and adolescents up to 18 years of age, the primary sequential series of IPV consists of 4 doses. The primary series is administered at 2 months, 4 months, 6-15 months and 4 years of age, or as age appropriate. A minimum of 6 months is required between the last 2 doses of IPV. A 4<sup>th</sup> dose in the routine IPV series is not necessary if the 3<sup>rd</sup> dose was given at 4 years of age or older and 6 months or more after the previous dose.

**MMR** - 2 doses of MMR vaccine after 12 months of age are required with a minimum of 28 days separating the doses. If a child has received 2 doses of MMR vaccine after 12 months of age, another dose after the 4<sup>th</sup> birthday is not necessary. Children 11-18 years of age not previously immunized with MMR should receive 2 doses. Individuals with 1 dose of MMR must receive an additional MMR vaccination. Students in schools of higher learning must receive 2 doses of MMR prior to entry.

**MenACWY** - Meningococcal conjugate vaccine should be administered to all children at age 11-12 years, a booster dose on/after 16 years. The minimum interval between doses of MenACWY vaccine is 8 weeks. Only 1 dose is needed if first dose given on or after age 16. This vaccine provides protection against meningococcal serogroups A, C, W, and Y, but not against serogroup B.

**MenB** - Teens age 16 through 18 years may be vaccinated routinely as an Advisory Committee on Immunization Practices Category B recommendation for provider-patient discussion. The 2-dose series protects against serogroup B meningococcal disease, but not serogroups A, C, W and Y. The 2 MenB vaccines are **not interchangeable**. The same vaccine product must be used for all doses in a series. Give 2 doses of either MenB vaccine: Bexsero, 1 month apart; Trumenba, 6 months apart. If dose 2 of Trumenba is administered earlier than 6 months, administer a 3<sup>rd</sup> dose at least 4 months after dose 2. For special situations use the Bexsero 2-dose series at least 1 month apart or the Trumenba 3-dose series at 0, 1-2, and 6 months.

**PCV** - All children should receive a 3-dose primary series and a booster if vaccination begun at ≤ 6 months of age; a 2-dose primary series and a booster if vaccination is begun between 7 and 11 months of age; a 2-dose series and no booster if vaccination is begun between 12 and 23 months of age. If vaccination is initiated at ≥ 24 months of age, the child should receive 1 dose of PCV. Children 24 through 59 months of age should receive a single dose of PCV13. For children with underlying medical conditions, a single supplemental PCV13 is recommended following primary series. High risk or presumed high risk for pneumococcal disease should be immunized with Polysaccharide Vaccine (PPSV) depending on the number of doses of PCV that they have received. PCV vaccination is required as part of the Daycare/Head Start Immunization Requirement for children less than 24 months of age.

**RV** - The 1<sup>st</sup> dose should be given between 6 and 14 weeks with the maximum age of 1<sup>st</sup> dose being 14 weeks 6 days of age. Maximum age for any dose is 8 months of age. Minimum interval between doses is 4 weeks. Monovalent RV1 is administered at 2 months and 4 months of age, a dose at 6 months is not required. Pentavalent RV5 is administered at 2 months, 4 months and 6-8 months. If RV brand is unknown a total of 3 doses are needed.

**VAR** - All susceptible children who are at least 12 months old through 18 years of age should be vaccinated. Administer the 2<sup>nd</sup> dose of varicella vaccine at age 4-6 years. VAR vaccine may be administered prior to 4-6 years, provided that ≥ 3 months have elapsed since the 1<sup>st</sup> dose and both doses are administered at ≥ 12 months of age. Susceptible persons aged ≥ 12 years should receive 2 doses at least 1 month apart. Children with a history of typical chickenpox are assumed to be immune to varicella and serologic testing is not warranted. History of chickenpox is not a contraindication to VAR vaccination.

**ABBREVIATIONS: COVID-19 SARS-COV-2 VACCINE; DTaP DIPHThERIA-TETANUS-ACELLULAR PERTUSSIS VACCINE; Tdap TETANUS AND DIPHThERIA TOXOIDS AND ACELLULAR PERTUSSIS VACCINE; Td ADULT TYPE TETANUS AND DIPHThERIA VACCINE; Flu INFLUENZA VACCINE; HepA HEPATITIS A VACCINE; HepB HEPATITIS B VACCINE; Hib HAEMOPHILUS INFLUENZA TYPE B VACCINE; HPV HUMAN PAPILLOMAVIRUS VACCINE; IPV INACTIVATED POLIOVIRUS VACCINE; MMR MEASLES-MUMPS-RUBELLA VACCINE; MenACWY MENINGOCOCCAL CONJUGATE VACCINE; MenB MENINGOCOCCAL VACCINE; PCV PNEUMOCOCCAL CONJUGATE VACCINE; RV ROTAVIRUS VACCINE; VAR VARICELLA VACCINE**