

Information Needed for Registration

Prospective **Kindergarten** students must be **five** years old by September 30, 2012. Prospective **Pre-Kindergarten** students must be **four** years old by September 30, 2012. All students must have the following documentation to submit a completed registration packet.

- Birth Certificate
- Social Security card
- Up-to-date immunization record
- Completed Registration form
- Four documents proving Zachary residence in the parent or legal guardian's name. Provisional custody or custody by mandate is not accepted.

Documents must include:

- **Original** mortgage or **original** lease agreement/rental contract on company letterhead
- Utility bill (City of Zachary – gas/water bill)

And at least 2 of the following:

- Entergy or DEMCO bill
- Telephone bill
- Tax Assessor's bill
- **Original, current** Medical/Medicare or social security insurance card
- Cable TV / Satellite bill
- **Original** Homestead Exemption

- Incoming first graders must have a drop slip from the previous school and a copy of the most recent report card, verifying grade level assignment.
- Both paying and free Pre-Kindergarten spaces are limited and applications will be processed on a first come, first served basis.
- \$50 supply fee for all K and 1st grade students. All supplies provided by school.
- **Families who wish to apply for free Pre-Kindergarten must provide proof of family income for an application to be considered. There is a \$50.00 registration fee.**
- **Families who wish to apply for paying Pre-Kindergarten will be required to submit a non-refundable \$50 registration fee to secure a space.** Tuition will be \$400.00 per month. It does not include breakfast or lunch but will cover all field trips, transportation to all field trips, and class field trip t-shirt.

Further questions can be answered at 654-2786.

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 HeadstartIncoming 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 _____

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



Louisiana Student Residency Questionnaire Form (Form Must Be Included In School Enrollment Packet)

Date District/Parish School Name Student Name SSN/ID# Male/Female Date of Birth Address Telephone Number Last School Attended Current Grade 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 X, Part C, 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. 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. Is the temporary living arrangement due to loss of housing or economic hardship?
3. Where is the student currently living? (Check all that apply)

Box containing options for where the student is currently living: 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

- 4. Does your child have a disability or receive any special education services? (Check One)
5. Does your child 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. 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. Does your child have siblings? (List names and grades)

9. The undersigned certifies that the information provided above is accurate.

Print Parent/Guardian Name/Adult Caring for Student Signature Date

(Area Code) Phone number Street Address City State Zip

School Use Only Free or Reduced Price Meals Form submitted/signed Copy Placed in Student's Cumulative Record

Homeless Liaison Use Only- Check All That Apply

Sheltered Doubled-Up Unsheltered/FEMA Hotel/Motel Unaccompanied youth Yes No

Print School Contact Title Signature (required) Date (Revised 3/2010)

OFFICE USE ONLY: RETURNING STUDENT NEW ENROLLEE CHANGE OF ADDRESS REQUESTED

Complete One Per Student

2012 – 2013 School Year
Zachary Community Schools Bus Service Request Form
Please NEATLY PRINT or Type All Information

Student's Name: _____.

I, (parent/guardian's name) _____, DO () DO NOT () want bus service for my child for the 2012-13 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 2012 - 13: _____ Student's Grade for 2012/13: _____

Parent/Guardian's Name: _____

Physical Home Address (No P.O. Boxes): _____

Town/City, Zip Code: _____

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):



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

Thanks in Advance for Your Assistance



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 "HIPAA 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 your child's school's website (click "Teacher Pages", then "Nurses" icon, then "Medication Packet"), and complete and return them to 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 Nurses



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

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.

ZACHARY COMMUNITY SCHOOL BOARD

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 information we collect about your child and their health is personal. Keeping health information of your child private is one 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 with the system's Privacy Officer your concerns about how their health information is shared. The law says:

1. We must keep their health information from others who do not need it.
2. You may ask us not to share certain health services information. Sometimes, we may not be able to agree to your request.

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 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 about providing and paying for such health services are being followed. We may also use the information to remind you about service or to tell you about treatment alternatives. We 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 treatment of services provided to your child for reimbursement by Medicaid.

We may share your health care information with health plans, insurance companies, or government programs to help get the benefits and so that the School System can be paid or pay for such health care or medical services.

In most cases, you may see your child's health information but the request cannot include psychotherapy notes or information gathered for judicial proceedings. There may be legal reasons or safety concerns that may 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 charge a small amount for copying costs.

If you think some of the health information is wrong, you may ask in writing that we correct or add to it. You may ask that the corrected or new information be sent to others who have received your child's health information from us. You may ask us for a list of where we sent the health information.

You may ask to have the health information sent to others. You will be asked to sign a separate form, called an authorization form, permitting the health information of your child to go to them. The authorization form tells us what, where and to whom the information must be sent. You can stop or limit the amount of information sent any time by letting us know in writing.

Note: A child 18 years old or older can give consent for his or her health information to be kept private from others unless the child signs an authorization form.

We follow laws that tell us when we have to share health information of your child even if you do not sign an authorization form. 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 to;
6. To the government to review how our programs are working;
7. To a provider or insurance company who needs to know if your child is enrolled in one of our programs;
8. To Worker's Compensation for work related injuries;
9. Birth, death and immunization information;
10. To the federal government when they are investigating something important to protect our country, the President and other government workers;
11. Abuse, neglect and domestic violence, if related to child protection or vulnerable adults; or
12. To parents and other designated by law.

We may also share health care information for permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.

This notice is yours. You may ask for a copy at any time. If there are important changes to this notice, you will get a new one within 60 days.

If you have any questions about this notice of privacy rights of your child or that such rights have been violated, you can 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 School Board, Secretary of Health and Human Services or Office of Civil Rights.

STATE OF LOUISIANA

HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

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.				
Name of School:			Grade:	
Student's Name: Last		First		M.I.
Student's Date of Birth:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	State or Country of Birth:	
Student's Mailing Address:		City:	State:	Zip Code:
Student's Physical Address:		City:	State:	Zip Code:
Name of Mother or Legal Guardian:	Home Phone: ()	Work Phone: ()	Cell Phone: ()	Employer:
Name of Father or Legal Guardian:	Home Phone: ()	Work Phone: ()	Cell Phone: ()	Employer:
Name of child's pediatrician or primary care provider:		Names of medical specialists or special clinics caring for your child:		
Parent or Legal Guardian Signature				Date
Please check the type of health insurance your child has: <input type="checkbox"/> Private <input type="checkbox"/> Medicaid/LaCHIP <input type="checkbox"/> None				
If your child does not have health insurance, would you like information on no cost health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
In case of emergency—if parent or legal guardian cannot be reached—contact the following:				
Name		Complete Phone Number ()		
My child has a medical, mental, or behavioral condition that may affect his/her school day: <input type="checkbox"/> No <input type="checkbox"/> 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.				
<input type="checkbox"/> ALLERGIES				
Allergy Type:				
<input type="checkbox"/> Food (list food(s)) _____				
<input type="checkbox"/> Insect sting (list insect(s)) _____				
<input type="checkbox"/> Medication (list medication(s)) _____				
<input type="checkbox"/> Other (list) _____				
Reactions: (Date of last occurrence if yes.)				
<input type="checkbox"/> Coughing (Date: _____)		<input type="checkbox"/> Hives (Date: _____)		<input type="checkbox"/> Rash (Date: _____)
<input type="checkbox"/> Difficulty breathing (Date: _____)		<input type="checkbox"/> Local swelling (Date: _____)		<input type="checkbox"/> Wheezing (Date: _____)
<input type="checkbox"/> Generalized swelling (Date: _____)		<input type="checkbox"/> Nausea (Date: _____)		<input type="checkbox"/> Other _____ (Date: _____)
Currently prescribed medications and treatments:				
<input type="checkbox"/> Oral antihistamine (Benadryl, etc.)		<input type="checkbox"/> Epi-pen		<input type="checkbox"/> Other _____
<input type="checkbox"/> ASTHMA				
Triggers: <input type="checkbox"/> Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) _____ <input type="checkbox"/> Other (list) _____				
Does your child experience asthma symptoms with exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Symptoms:				
<input type="checkbox"/> Chest tightness, discomfort, or pain <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Coughing <input type="checkbox"/> Wheezing <input type="checkbox"/> Other _____				
Currently prescribed medications and treatments: _____				
Date of last hospitalization related to asthma _____ Date of last emergency room visit related to asthma _____				
Does your child have a written asthma management plan? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Is peak flow monitoring used? <input type="checkbox"/> No <input type="checkbox"/> Yes				

**ZACHARY COMMUNITY SCHOOL SYSTEM
MEDICAL HISTORY UPDATE FORM**

To Be Completed By Doctor

(This information will be utilized by the school nurse to provide health services to students.)

Student's Name _____ **DOB** _____ **Grade** _____

School _____ **Teacher** _____ **School Nurse** _____

CURRENT DIAGNOSIS & MEDICAL STATUS *(additional information may be attached to this form)*

Recommendations For Student Integration Into The School Setting

Activity Restrictions/Limitations _____

Accommodations _____

Nutritional/Dietary _____

Adaptive Physical Education _____

Physical Therapy _____

Occupational Therapy _____

Special Procedures _____

Return to Clinic _____

Physician's Signature _____ *Date* _____

Print Physician Name Here _____ *Office #* _____

Address _____ *Fax #* _____



ZACHARY COMMUNITY SCHOOLS IMMUNIZATION REQUIREMENTS FOR PRE-K

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-----4 Doses

IPV-----3 Doses

MMR----- 1 Dose

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

HBV----- 3 Doses

HIB----- 4 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 students' immunizations. Any immunization given too early or out-of-sequence will automatically not be accepted by the LINKS application. Please check with your child's doctor to see if their immunizations are up-to-date. If an immunization was given too early and your doctor does not want to repeat the dose, we will need a note from the doctor 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 AND HOSPITALS
OFFICE OF PUBLIC HEALTH
IMMUNIZATION SCHEDULE

2011 through 2012

Depending on the child's age, choose the appropriate initial set of immunizations.

RECOMMENDED SCHEDULE FOR IMMUNIZATION OF INFANTS AND CHILDREN	ACCELERATED SCHEDULE FOR CHILDREN STARTING IMMUNIZATIONS LATE	
AGE	CHILDREN 4 MONTHS TO 7 YEARS OF AGE	CHILDREN 7-18 YEARS OF AGE
Birth HBV	1st Visit ‡ DTaP, Hib*,IPV,MMR,HBV,HAV, Var, Flu, PCV ^o	1st Visit Td, IPV, HBV, MMR, Var
2 Months [§] DTaP, Hib, IPV, HBV, PCV ^o , RV	2nd Visit DTaP, Hib, HBV, IPV, PCV, Flu (4 wks. after the 1st visit)	2nd Visit Td, IPV, HBV, MMR (4 wks. after the 1st visit)
4 Months DTaP, Hib, IPV,PCV, RV	3rd Visit DTaP, Hib, PCV (4 wks. after the 2nd visit)	3rd Visit Td, IPV, HBV (6 mos. after the 2nd visit)
12-15 Months DTaP, Hib, MMR, Var, PCV, HAV	4th Visit DTaP, Hib, HBV, IPV, PCV,HAV (6 mos. after the 3rd visit)	11-12 Years Tdap, MCV4, HPV [∞] (Var, MMR,HBV,IPV if needed)
18-23 Months HAV	4 Years Of Age † DTaP, IPV, MMR (Var if needed) Or Prior To School Entry	16 Years MCV4
4 Years Of Age Or Prior To School Entry DTaP, IPV, MMR, Var	11-12 Years Tdap, MCV4, HPV [∞] (Var, MMR, HBV if needed)	
11-12 Years Tdap, MCV4, HPV [∞] (VAR, MMR, HBV If needed)	16 Years MCV4	
16 year MCV4		

VACCINE ABBREVIATIONS

HBV HEPATITIS B VACCINE, **HAV** HEPATITIS A VACCINE, **DTaP** DIPHTHERIA - TETANUS - ACELLULAR PERTUSSIS VACCINE, **Hib** HAEMOPHILUS INFLUENZA TYPE B VACCINE,
Td ADULT TYPE TETANUS AND DIPHTHERIA VACCINE , **Tdap** TETANUS AND DIPHTHERIA TOXOIDS AND ACELLULAR PERTUSSIS VACCINE, **IPV** INACTIVATED POLIOVIRUS VACCINE, **RV** ROTAVIRUS VACCINE, **FLU** INFLUENZA VACCINE, **MCV4** MENINGOCOCCAL CONJUGATE VACCINE, **HPV** HUMAN PAPILOMAVIRUS VACCINE
MMR MEASLES - MUMPS - RUBELLA VACCINE, **VAR** VARICELLA VACCINE, **PCV** PNEUMOCOCCAL CONJUGATE VACCINE.

THE SCHEDULE ABOVE AND THE FOLLOWING GUIDELINES ARE SUMMARIES, FOR MORE DETAILED INFORMATION ON EACH VACCINE, REFER TO THE MANUFACTURERS' PRODUCT INSERT.

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

HAV - Hepatitis A is recommended for all children at age 1 year (i.e. 12-23 months). The two doses in the series should be administered at least 6 months apart.

DtaP - DTaP vaccine is recommended and can be administered any time after 6 weeks of age. The 4th dose of DTaP vaccine should be given at least 6 months after the 3rd dose. Pediatric DT (Diphtheria-Tetanus) should be substituted for DTaP when Pertussis vaccine is contraindicated. Td vaccine should be used for those 7 – 10 years of age. Tdap is recommended at age 11-12 years for those who have completed the recommended DTaP series and have not received a Td booster 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.

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

PCV - All children should receive a 3 dose primary series and a booster if vaccination begun at ≤ 6 mos. 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. 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 (PPV) depending on the number of doses of PCV that they have received. PCV vaccination is required as part of the Daycare/HeadStart Immunization Requirement for children less than 24 months of age.

IPV - For infants, children and adolescents up to 18 years of age, the primary sequential series of IPV consists of four doses. The primary series is administered at 2 months, 4 months, 6-15 months and 4 years of age, or as age appropriate.

RV - Administer the first dose between 6 and 14 weeks, 6days of age. Maximum age for any dose is 8 months. Minimum interval between doses is 4 weeks. Monovalent RV1 is administered at 2 and 4 mos. of age, then a dose at 6 mos. is not required. Pentavalent RV5 is administered at 2 months, 4 months and 6 – 8 months. If RV brand is unknown a total of three (3) doses are needed.

HPV - Administer the first dose of HPV vaccine between 11-12 years. Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose. HPV catch up schedule: Four week minimum interval between dose 1 and dose 2. A minimum interval of 12 weeks required between dose 2 and dose 3. The 3rd dose should be given at least 24weeks after the 1st dose.

MMR - Two doses of MMR vaccine after 12 months of age are required with a minimum of 28 days separating them. • If a child has received 2 doses of MMR vaccine after 12 months of age, another dose after the 4th birthday is not necessary. • Children 11-18 years of age not previously immunized with MMR should receive two doses. Individuals with one dose of MMR must receive an additional MMR Vaccination. • Students in schools of higher learning must receive 2 doses of MMR prior to registration.

MCV4 - 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 MCV vaccine is 8 weeks.

Var - All susceptible children who are at least 12 months old through 18 years of age are eligible. Administer the second dose of Varicella at age 4 – 6 years. Varicella Vaccine may be administered prior to 4-6 years, provided that ≥ 3 months have elapsed since the first dose and both doses are administered at ≥ 12 months. Susceptible persons aged ≥ 12 years should receive two doses at least 1 month apart. Two doses of Varicella is required as part of the School immunization requirement and also for children 4 years and older that are enrolled in Day Care, Headstart, and Pre-K. Parental history of having had chickenpox is acceptable. Physician documentation is not necessary at this time.

Flu - Routine annual influenza vaccination is recommended for all children 6 mos – 18 years. Two doses administered at least 1 month apart are recommended for children aged 6 mos – 8 yrs who are receiving the influenza vaccine for the 1st time, as well as, those who only received 1 dose in their previous year of vaccination, if applicable.

§ • DTaP, IPV, HBV, PCV, RV and Hib can be administered as early as 6 weeks of age and simultaneously.

† • **LOUISIANA STATE LAW** requires prior to school entry: 2 doses of MMR, 3 Hepatitis B, 2 Varicella and booster doses of DTaP and Polio vaccines on or after the 4th birthday and prior to school entry. A preschool dose is not necessary if the 4th dose of DTaP and the 3rd dose of IPV are administered after the 4th birthday. Sixth graders (11 -12 years of age) are required: 1 Tdap, 2 VAR, 2MMR, 3 HBV, 1 MCV.

‡ • 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.

* • see Hib section ∞ • see HPV section ◇ • see PCV section

Adolescents and post adolescents (11-18 yrs.) should be vaccinated with a second dose of MMR, Varicella (if no history of disease) and Hepatitis B if no history of previous vaccination.

Four Day Grace Period: All vaccine doses administered less than or equal to four days before the required minimum interval or age shall be considered valid doses when evaluating a student record for compliance with immunization requirements for schools and child care entry. The Advisory Committee on Immunization Practices (ACIP) continues to recommend that vaccine doses not be given at intervals less than the minimum intervals or earlier than the minimum age.

For additional information about vaccines, including precautions and contraindications for immunizations and vaccine shortages, please visit the National Immunization Program Web Site at www.cdc.gov/vaccines or call the National Immunization Hotline at 800-232-2522 (English) or 800-232-0233 (Spanish).

LOUISIANA

IMMUNIZATION REQUIREMENTS

11 – 12 Years of Age, Entering 6th grade or any other grade	4 Years and older, Entering Kindergarten, Pre-K, Daycare or Head Start	Under 4 Years, Entering Pre-K, Daycare or Head Start
One (1) Meningococcal Vaccine (MCV-4)	Booster dose of Poliovirus vaccine (IPV) received on after the 4 th birthday.	Three (3) doses of Pneumococcal Conjugate vaccine (PCV) for children less than 24 months of age. If a child is less than 24 months of age and has received 4 doses of PCV-7 he/she is to get a single dose of PCV-13 for Daycare and Head Start. Two (2) or (3) Three doses of polio vaccine (IPV)
Two (2) doses of Measles, Mumps, Rubella vaccine (MMR)	Two (2) doses of Measles, Mumps, Rubella vaccine (MMR)	One (1) Or Two (2) doses of Measles, Mumps, Rubella vaccine (MMR)
Three (3) doses of Hepatitis B vaccine (HBV)	Three (3) doses of Hepatitis B vaccine (HBV)	Three doses of Hepatitis B vaccine (HBV)
Two (2) doses of Varicella vaccine (Var)	Two (2) doses of Varicella vaccine (Var)	One (1) dose of Varicella Vaccine (Var)
One (1) dose of Tetanus Diphtheria Acellular Pertussis vaccine (Tdap)	Booster dose of Diphtheria Tetanus Acellular Pertussis vaccine (DtaP) received on after the 4 th birthday	Three (3) or Four (4) doses Diphtheria Tetanus Acellular Pertussis vaccine (DtaP)
		Three (3) doses of Haemophilus Influenza Type B vaccine (Hib)