DEPARTMENT OF DEFENSE
EDUCATION ACTIVITY
4040 NORTH FAIRFAX DRIVE
ARLINGTON, VIRGINIA 22203-1635

DoDEA Immunization Requirements
August 2010

Students who enroll in DoDEA schools are required to meet specific immunization requirements. These requirements, displayed below, represent the minimum requirement and do not necessarily reflect the optimal immunization status for a student. This copy of the *DoDEA Immunization Requirements (August, 2010)* is provided to parents for informational purposes only. Official proof of immunization must be provided to school officials at the time of initial registration.

As of July 2010, DoDEA aligned with the immunization guidance prescribed by the Interstate Compact on Educational Opportunity for Military Children. As a result, provision has been made for students transferring to a new location allowing up to 30 calendar-days after enrollment to present current immunization documentation.

IMMUNIZATIONS	MINIMUM DoD REQUIREMENTS As Recommended by the Advisory Committee on Immunization Practice (ACIP) at Center of Disease Control (CDC)
Diphtheria, Petanus, Pertussis Eg., DTP,DTaP, DTwP, DT, DTaP-Hib, DTaP-HepB-IVP, Tdap, TD	Four (4) doses; At least one MUST be administered after the 4th birthday ACIP Recommendation: • The usual schedule is a primary series of 4 doses at 2m, 4m, 6m and 15-18m of age • If the fourth dose of DT, DTP or DTaP is administered before the fourth birthday, a booster (fifth) dose is recommended at 4 -6 years of age (5a) Tdap or Td booster doses: A single Tdap booster dose is recommended for children 11-12 years old, if 5 years has elapsed since the last dose; then Td booster every 10 years with Td (5b)
HEPATITIS A Eg. HepA	Two (2) doses ACIP Recommendation: • HepA is recommended for all children at 1 year of age The two doses in the series should be administered at least 6 months apart
HEPATITIS B Eg. HepB, Hib-HepB, DTaP-HepB-IVP	Three (3) doses: ACIP Recommendation: • The standard schedule is 0, 1 and 6 months • The first dose is recommended shortly after birth with the 2nd dose administered at age 1-2months. The 3rd dose should be administered ≥ 24 wks • Merck's Recombivac-HB brand of HepB vaccine can be given as a 2-dose series for adolescents 11 to 15 years of age Catch-up Schedule: • 3-dose series may be started at any age • Minimum spacing for children and teens: 4 wks between dose 1 and dose 2 and 8 wks between dose 2 and dose 3

Haemophilus Influenza type b Eg. Hib, Hib-HepB, DTaP-Hib	Two (2) to four (4) doses ACIP Recommendation: • Primary immunization occurs at 2m, 4m, 6m, and 12m to 15 m (booster dose) • Merck's PedvacHIB brand of Hib vaccine, 3 doses are needed (2,4 and 12-15m) Catch-up Schedule: • If dose 1 is given at 12-14m, give a booster dose 8 weeks later • Unvaccinated children from ages 15m up to 5 years need only 1 dose Hib is not routinely given to children 5 years old and older
IVP/OPV Polio Vaccine	Three (3) doses; At least one dose must be administered <u>after</u> the 4th birthday ACIP Recommends: • Usual schedule is a primary series of 4 doses at 2m,4m, 6-18m and 4-6 years of age. • All doses should be separated by at least 4 weeks • If dose 3 is given after the 4th birthday, dose 4 is not needed
MMR/MMRV Measles, Mumps, Rubella	Two (2) doses ACIP Recommendation: • Dose 1 is given at 12-15m • Dose 2 routinely at age 4 but may be administered at any visit, if 4 weeks have elapsed since the first dose and both doses are administered beginning at or after 12 months. • Those who have not previously received the second dose should complete the schedule by age 11-years
MENINGOCOCCAL MCV4 (Menactra®)	One (1) dose ACIP Recommends: • MCV4 should be given to all children at the 11-12 years of age as well as unvaccinated adolescents at High School entry (15 years of age) Any adolescent over 11 years of age may receive this vaccine • Vaccination against invasive meningococcal disease is recommended for children and adolescents ≥ 2 with terminal deficiencies or anatomic or functional asplenia and certain other high risk groups
VARICELLA Chicken Pox	Two (2) doses ACIP Recommendations: • Dose #1 Minimum age 12 months • Dose #2 at age 4 years. However the second dose may be administered before age 4 provided at least 3 months have elapsed since first dose • For children 12mths-12 years, the minimum interval between doses is 3 months; However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid • For children age 13 years and older, the minimum interval between doses is 28 days • Immunization is NOT required in people with a history of natural disease (chickenpox)
PPD TB tine/ monovac BCG	Routine testing is no longer necessary unless risk factors are identified as determined by local medical command.

Heidelberg Schools
Robinson Barracks Elementary/ Middle School
School Year 2012-2013 Student Grade______________

MEDICAL POWER OF ATTORNEY

In the event that my dependent (NAME)________________________________DOB____________________, is injured or becomes ill, necessitating immediate medical examination or care, while under the supervision of or while participating in, any activities sponsored by a Heidelberg School, I authorize and release to any agent or employee of Heidelberg Schools to take my dependent to any U.S. military facility or any civilian hospital if deemed necessary by the above referenced individual.

I understand that the above named personnel of Heidelberg Schools will use all diligent and reasonable efforts to contact my spouse or me. If Heidelberg School personnel of a or the U.S. treatment facility cannot contact either my spouse nor me after reasonable attempts, I authorize and release any physician or other qualified medical personnel to examine my child. I authorize any and all emergency care necessary for treating injuries or illness involving immediate danger to life or limb of my dependent. I further authorize non-emergency care and necessary treatment such as suturing superficial lacerations; treating colds, minor allergies, and minor gastro-intestinal upsets; splinting sprains; casting uncomplicated fractures; or other similar treatments.

MEDICAL INFORMATION ABOUT THE ABOVE NAMED DEPENDENT (to be completed by parent/guardian) for the purpose of sharing information with teachers and health care personnel on a need- to-know basis).

My dependent has the following medical problem (s) (such as glasses, diabetes, seizures, asthma, heart, ADHD, or kidney disease):
____

My dependent is allergic to the following: ____

-Inhalers and Epi-PEN's must have orders from MD

My dependent takes the following medications on a regular and/or "as needed" basis (list name, amount, and purpose of each):
____

My dependent will be taking medication at school [] NO []YES List medications_____________________________
____

NOTE: Medication permission form MUST be filled out and signed by prescribing medical doctor and parent annually

I will provide the required medication permission form/action plan for school medications: Yes [] No [] N/A []

PARENT/ EMERGENCY CONTACT INFORMATION (to be completed by parent)
Sponsor's name: ____________________________________ Home phone #: _______________________
Sponsor's unit: __________________________________ Rank: ________________________________
Sponsor's Work Phone #_____________________________ Cell phone #: ___________________________
Sponsor's home address: ____
Sponsor's mailing address:____
Spouse's name: ___________________________Work phone #: ____________________________________
Cell phone #2: _____________________________________
Insurance Carrier: [] TRICARE [] Other_____________________________ **Civilian "Pay Patient"**? _____Yes ______ No

Sponsor's Social Security Number-Last 4__________

<u>EMERGENCY CONTACT INFORMATION</u>: To use in case of emergency if parents/guardians are unavailable:

Contact Name (**<u>other than spouse</u>**): _________________________________ Home phone #___________________
Cell #___________________________________ Work Phone #_____________________________________

Additional comments: ____
I AGREE TO NOTIFY THE SCHOOL IMMEDIATELY OF ANY CHANGES IN THE ABOVE INFORMATION.

Signature of Parent/Guardian____ Date __________________

PRIVACY ACT NOTICE: AUTHORITY: Title V, Sec. 301. PRINCIPAL PURPOSE: To refer to emergency medical facilities in parents'/guardians' absence. ROUTINE USES: (a) To obtain emergency medical care when parents cannot be reached; (b) To provide emergency contact names; (c) To supply health and medical information about student. This form is used by DoDEA employees and trained medical personnel in emergency. Social Security number of sponsor is required by military medical facilities in case of emergency referral. MANDATORY/VOLUNTARY DISCLOSURE/EFFECT OF NONDISCLOSURE: Mandatory. School personnel will not be able to provide emergency care and health services in parents' absence.

For your convenience, the HMS nurse will share information with the CYS nurse and USAMH **only at your request**. Please complete this form if you would like the HMS to provide information indicated below so that you do not have to come to the school to request a copy of documents in person during the school year (i.e. physical forms, immunization, asthma care plan, Epi-Pen care plan, seizure action plan)

DEPARTMENT OF DEFENSE
DEPENDENTS SCHOOLS
Robinson Barracks Elementary/ Middle School

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION
PART I

Name____
(Student name)

I authorize Robinson Barracks Elementary/Middle School to release the following medical information to:

☐ Child and Youth Services, ☐ US MEDDAC, and /or ☐ ______________________________

Please initial appropriate box:

_______Physical Form
_______Medication Permission Form
_______Immunization Information
_______Epi-Pen Care Plan (if applicable)
_______Asthma Care Plan (if applicable)
_______Diabetic Care Plan (if applicable)
_______Seizure Action Plan (if applicable)

This release is effective for three year(s) from the date of execution; however I may revoke it at any time by providing notice in writing to the above named party.

______________________________________ ______________________
Parent/Legal Guardian of Patient Date

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Permission for Health Screenings
PART II

I give permission for my child to receive the following health screenings in the health office at Robinson Barracks Elementary/Middle School:

- **Hearing screening**
- **Vision screening**
- **Dental screening (as indicated)**
- **Scoliosis screening (curvature of the spine)**
- **Blood pressure (as indicated)**

The screenings help identify possible health problems but <u>should not replace</u> annual medical examinations with a physician.

______________________________________ ______________________________
Parent/Sponsor signature **Date**

☐ **I refuse the above Health Screenings.** ______________________________ _______________
Parent/Sponsor signature **Date**
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EDUCATION ACTIVITY
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DoDEA Immunization Requirements
November 2011

Students who enroll in DoDEA schools are required to meet specific immunization requirements. These requirements represent the minimum requirements and do not necessarily reflect the optimal immunization status for students. This copy of *DoDEA Immunization Requirements* is provided to parents for informational purposes only. Official proof of immunization must be provided to school officials at the time of initial registration and upon request of school officials to verify immunization compliance i.e., copy of child's immunization/shot record.

The immunizations noted below are for students who are age five years old and older. For students who are under the age of five years, immunization compliance is based on the age appropriate immunization schedule established by the Advisory Committee on Immunization Practices (ACIP).

IMMUNIZATION	MINIMUN DoDEA REQUIREMENT FOR SCHOOL ATTENDANCE
+ Diphtheria, Tetanus, Pertussis DTaP, DT Tdap	* DTaP, DT series completed by age 4 years or on schedule for completion. If the fourth dose of DTaP, DT was administered before the fourth birthday, a booster (fifth) dose is required for initial school entry. * Tdap required at age 11 years old.
+ Hepatitis A	* Series completed prior to initial entry into school or on schedule for completion.
+ Hepatitis B	* Series completed prior to initial entry into school or on schedule for completion.
+ Measles, Mumps, Rubella	* Series completed prior to initial entry into school or on schedule for completion.
Meningococcal	* Series initiated at age 11 years. Booster at age 16 years.
+ Polio	* Series completed by age 4 years or on schedule for completion. If the fourth dose of Polio was administered before the fourth birthday, an additional dose is required for initial school entry.
+ Varicella	* Series completed prior to initial entry into school or on schedule for completion.
Tuberculosis	Routine testing is no longer necessary unless risk factors are identified as determined by local medical command.
Influenza	Requirement determined by local medical command.

Information on immunizations and dosage scheduling provided by the Advisory Committee on Immunization Practices http://www.cdc.gov/vaccines/recs/acip, the American Academy of Pediatrics, http://aap.org, and the American Academy of Family Physicians http://aafp.org.

As of July 2010, DoDEA aligned with the immunization guidance prescribed by the Interstate Compact on Educational Opportunity for Military Children. As a result, provision has been made for students transferring to a new location allowing up to 30 calendar-days after enrollment to obtain any immunization(s) required by the receiving state. For a series of immunizations, initial vaccination must be obtained within 30 days of initial enrollment.

+ May be administered in additional combination vaccines.
* Series dose spacing based on immunization schedule for persons aged 4 through 18 years.

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
STUDENT HEALTH HISTORY

PRIVACY ACT STATEMENT:

AUTHORITY: 10 U.S.C. sections 2164 and 20 U.S.C. sections 921-932.

PRINCIPAL PURPOSE: To obtain health information about a student enrolling in Department of Defense Education Activity (DoDEA) schools and programs to protect and enhance student health and to promote a safe school environment.

ROUTINE USES: DoDEA may release information without prior consent within the DoD when needed to perform an official DoD duty, in accordance with 5 U.S.C. section 552a(b)(1). DoDEA also may release information outside the DoD, in accordance with 5 U.S.C. section 552a(b)(2-12), and the "Blanket Routine Uses," published at http://www.defenselink.mil/privacy/notice/osd. Examples of release may include for valid medical, law enforcement or security purposes, or for use in litigation involving the DoD.

DISCLOSURE: Disclosure to the Agency of the information requested on this form is voluntary; but failure to provide all requested information may result in the delay or denial of student services.

NAME (*Last, First, Middle Initial*)	Check: ☐ Female ☐ Male	Date of Birth: _____/_____/_____ **(mm / dd / yyyy)**

MEDICAL HISTORY: CHECK (✓) ALL THAT APPLY AND EXPLAIN BELOW OR ATTACH ADDITIONAL PAGE(S).

	VISION
	Wears glasses for reading
	Wears glasses full time
	Wears contacts
	Color deficiency
	Other
	HEARING
	Frequent ear infections
	Ear tubes Insertion date: Are tubes currently in place: Right? YES ☐ NO ☐ Left? YES ☐ NO ☐
	Hearing loss: Right ☐ Left ☐
	Other
	ENDOCRINE
	Diabetes
	Other
	DERMATOLOGY
	Eczema
	Other
	GENITOURINARY
	Bladder control problems
	Urinary track infections
	Other

	RESPIRATORY
	Bronchitis
	Cystic fibrosis
	Sinusitis
	Other
	CARDIOVASCULAR
	Sickle cell disorder
	Heart murmur
	Hemophilia/Other Bleeding disorders
	Rheumatoid heart disease
	Other
	MUSCULOSKELETAL
	Muscular Dystrophy
	Scoliosis
	Other
	GASTROINTESTINAL
	Hernia
	Other
	DENTAL
	Braces
	Other

	ASTHMA
	Date of Diagnosis: **Inhaler needed:** **@ school** * YES ☐ NO ☐ **@ home** YES ☐ NO ☐
	PSYCHIATRY
	Anorexia
	Bulimia
	Autism
	ADD/ADHD
	Depression
	Substance abuse history
	Suicidal
	Other
	NEUROLOGICAL
	Cerebral Palsy
	Frequent headaches
	Migraines
	Spina Bifida
	Seizures
	Sleep disorder
	Other

	ALLERGIES (A SHSG Form H-3-7 should be completed.)
	Bee sting
	Wasp sting
	Other insects
	Seasonal
	Environmental
	Food
	Lactose intolerance (The school will need a letter from the doctor stating that the student is lactose intolerant.)
	PROCEDURES: (A SHSG Form H-4-9 should be completed.)
	My child will/may require special health care procedures during the school day. (See page 2.)
	RESTRICTIONS
	My child has a condition that warrants restriction of activities during school hours. (See page 2)
	My child takes daily medication at home.
	My child will need medications during school hours. (* See page 2.)
	My child may need emergency medications during school hours. (* See page 2.)

*** MEDICATIONS DURING SCHOOL HOURS:** SHSG: H-3-2, 3-3 and/or 3-8 forms must be signed by the physician and a parent; and must accompany prescribed medications that are to be given during school hours. The medication will be in the original container properly labeled by the physician or pharmacy. All medications will remain at school for the duration of the prescription.

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
STUDENT HEALTH HISTORY

Explain any of the above here or attach additional pages.

Identify any special health care procedures that your child may require during the school day:

Identify any condition that warrants a restriction of student activity, specify the nature and duration of the limitation and any other information that would help the school assist your child:

Identify any condition that warrants daily and/or emergency administration of medicine for your child and list those medications:

Parent/Sponsor's Signature:	Primary phone #:	Date: