2024 Camp Hawk

What: Tolland Family Resource Center Camp Hawk offers a high quality and exciting summer program for children ages five through twelve. Children must be five by July 1, 2024.

Where: Tolland Intermediate School for weeks 1- 9. Birch Grove Primary School for week 10.

Dates: The summer program will run from Monday, June 17, 2024, to Friday, August 23, 2024. (No camp on Thursday, July 4, 2024, in observance of the Independence Day holiday.)

Hours: The camp is offered Monday through Friday from 9:00 AM to 4:00 PM. Extended care is available from 7:00 AM-9:00 AM and/or 4:00 PM-6:00 PM for an additional fee. The one fee covers both am and pm extended care.

Cost: Full Week tuition is $190.00 per week from 9:00 AM-4:00 PM. Full Week extended care is an additional $45.00 per week for AM and/or PM care. For Camp Hawk 2024 the FRC will cover the fees for field trips and special activities.

Part Time Rate: All children must enroll for a minimum of 2 days per week. The part time rate is $45.00 per day from 9:00 AM-4:00 PM. Part time extended care is an additional $15.00 per day for AM care and/or PM care. For Camp Hawk 2024 the FRC will cover the fees for field trips and special activities.

Registration: Registration begins March 15, 2024. The registration fee is $50.00 per child or $75.00 per family. You may register for as many weeks as you wish. Return completed registration forms to Tolland Family Resource Center, 247 Rhodes Road Tolland, CT 06084. Please make checks payable to the Tolland Board of Education.

General Expectations: For safety concerns, all campers are to follow Camp Hawk's expectations, guidelines, and policies as listed in our handbook. Handbooks will be available on our website by June 1, 2024. **Please make sure to read!**

Quality Staff: Our staff is experienced and qualified. Many of our staff work in the School Age Care Program, which provides continuity for the children. Staff members are first aid & CPR trained and medication certified.

Meals: Children need to bring their own lunch, a morning snack, an afternoon snack, and a beverage in a self-cooled container. No microwave or refrigerator is available. Water is available for children throughout the day.

Theme Weeks: Each week has a fun theme! Children participate in planned activities geared toward the theme.

Field Trips and Special Guests: The children will have the opportunity to experience in-house field trips/special guests as well as in person trips throughout the summer. The camp will take hiking trips and weekly field trips to Newhoca Park (day to be determined by Vernon Parks & Recreation).

Inclement weather: At times when the weather does not allow the children to go outside (i.e., extreme heat or rain), the staff will plan special activities for the children inside.

What to Bring: Please put your child's name on every item brought to camp. Each child must bring the following: backpack, change of clothes, bathing suit, towel, lunch, and snacks (in self-cooled container), **water bottle**, sunscreen, and insect repellant (left in their locker). Please apply sunscreen before arriving each day. Children may reapply their own sunscreen as needed.

If you have questions about any program component, please call the Family Resource Center at 860-870-6750 x5.

Camp Hawk
2024 Theme Weeks

Week 1 (June 17-21) **"Summer Palooza"** **Field Trip Thursday – Gillette Castle**	**Week 6 (July 22-26)** **"Recycle It"** **Field Trip Friday – Mad Science**
Week 2 (June 24-28) **"Life's A Beach"** **Field Trip Thursday – Mystic Aquarium**	**Week 7 (July 29-August 2)** **"It's in the Stars"** **Field Trip Friday – Springfield Museums**
Week 3 (July 1-July 5, closed Thurs., 7/4) **"Stars and Stripes"** **Field Trip – To Be Determined**	**Week 8 (August 5-9)** **"Animal Planet"** **Field Trip Thursday – Southwick Zoo**
Week 4 (July 8-12) **"In the Garden"** **Field trip Friday – Wickham Park**	**Week 9 (August 12-16)** **"Camp Spirit"** **Field Trip Thursday - Hike a Tolland Trail**
Week 5 (July 15-19) **"STEAM Week"** **Field Trip Friday – CT Science Center**	**Week 10 (August 19-23) *** **"Goodbye Summer"** **Field Trip Thursday – Spare Time Bowling**

***Week 10 will be held at Birch Grove Primary School.**
The last day of camp is Friday, August 23rd.

Tolland Family Resource Center
Camp Hawk
2024 Registration Form

Registrations must be submitted with applicable fees to be complete.

CHILD/FAMILY INFORMATION: ***Please print clearly.***

Child's Name:	D.O.B:	
Grade in September 2024:	Gender:	
Home Address:	Town:	State/Zip Code:
Ethnicity: not Hispanic or Latino ☐ Hispanic or Latino ☐		
Race (select one or more of the following): American Indian or Alaska Native☐ Asian ☐ Black or African American☐ Native Hawaiian or other Pacific Islander ☐ White ☐		

Parent/Guardian Name:	Gender:	Relationship to Child:
Home Address:	Town:	State/Zip Code:
Home #:	Work #:	Cell #:
Employer:	Email Address:	
Ethnicity: not Hispanic or Latino ☐ Hispanic or Latino ☐		
Race (select one or more of the following): American Indian or Alaska Native☐ Asian ☐ Black or African American☐ Native Hawaiian or other Pacific Islander ☐ White ☐		

Parent/Guardian Name:	Gender:	Relationship to Child:
Home Address:	Town:	State/Zip Code:
Home #:	Work #:	Cell #:
Employer:	Email Address:	
Ethnicity: not Hispanic or Latino ☐ Hispanic or Latino ☐		
Race (select one or more of the following): American Indian or Alaska Native☐ Asian ☐ Black or African American☐ Native Hawaiian or other Pacific Islander ☐ White ☐		

In case of emergency, which parent/guardian listed above should we contact first? _____

Unless informed otherwise, the Tolland Family Resource Center assumes both parents listed above may pick up the child. If a parent may not pick up the child, legal documentation of that fact is required. **It is your responsibility to let us know of changes in residency, billing, custody, & contact information.**

EMERGENCY INFORMATION

If the Tolland Family Resource Center staff cannot reach the parents/guardians, the following individuals have permission to make decisions about my child's care, including permission to pick up my child from the FRC in case of emergency.

Name:		Relationship to child:
Home #:	Cell #:	Work #:
Name:		Relationship to child:
Home #:	Cell #:	Work #:

CHILD PICK UP AUTHORIZATION

I give permission for my child to be released from the Family Resource Center program to the people listed below at any time. I understand that the FRC staff requires photo identification of authorized pick-up people before releasing my child.

Name:		Relationship to child:
Home #:	Cell #:	Work #:
Name:		Relationship to child:
Home #:	Cell #:	Work #:
Name:		Relationship to child:
Home #:	Cell #:	Work #:

ADDITIONAL INFORMATION

With whom does the child ***primarily*** reside? Both ☐ Mother ☐ Father ☐ Split Custody ☐ Other ☐
If other selected for primary residence, please explain:
Parent/Guardian Responsible for billing: Both ☐ Mother ☐ Father ☐ Other ☐
If other selected for billing responsibility, please explain:
Primary language spoken at home:
Additional languages spoken:
Siblings' Names & D.O.B.:

HEALTH/WELLNESS INFORMATION

Are your child's immunizations up to date? Y ☐ N ☐
Does your child take any prescribed or over-the-counter medication regularly? Y ☐ N ☐
If yes, please list medication name(s):
If your child needs medication during camp hours, it must be provided in the original container to the attending staff and accompanied by an Authorization for the Administration of Medication form, completed by your physician.
Does your child have any allergies (food, medication, seasonal, etc.)? Y ☐ N ☐
If yes, please explain:

Does your child follow a special diet (gluten-free, vegetarian, vegan)? Y ☐ N ☐
If yes, please explain:
Does your child have any chronic health concerns (asthma, seizures, diabetes)? Y ☐ N ☐
If yes, please explain:
Has your child been diagnosed with any developmental disorders? Y ☐ N ☐
ADD/ADHD ☐ ASD ☐ Hearing ☐ Language/Speech ☐ Vision ☐ Other ☐ _____ None ☐
Does your child receive any of the following services? Y ☐ N ☐
Special Education ☐ 504 ☐ IEP ☐ 1:1 Aide ☐ Other ☐ _____ None ☐

Additional Health/Wellness Information (special circumstances, sensitivities, social/emotional concerns, etc.)

Is your child covered by any hospitalization/medical care policy? Y ☐ N ☐		
Name of Insurance Company:		Phone #:
Address:	City:	State/Zip:
Policy Holder's Name:		Policy Number:
Physician:		Phone #:
Please list a preferred hospital:		

Please review the information you have provided on this registration form to ensure accuracy.

_____I do / _____do not give permission for my child to be photographed. (Pictures may be placed in the FRC/Camp Hawk photo album, scrapbook or displayed in the classroom. Pictures may also be displayed at other FRC/Camp Hawk events, such as the Open House, town childcare fair etc. Pictures will not be placed in the newspaper without prior written approval. Pictures will never be placed on social media.)
_____ I do / _____do not give permission for my child to view PG movies occasionally.
_____ I do / _____do not give permission for my child to self-apply sunscreen and insect repellent, as needed. **Parents are asked to check their child(ren) each day for ticks. The FRC is not responsible for any insect related illness.**

Signature _____ Date Signed _____

CAMPER'S NAME:_____ **T-SHIRT SIZE:**_____

Enrollment Options (Please check below):

Full Week:
$190.00 per week
9:00 AM-4:00 PM _____
*For Camp Hawk 2024 the FRC will cover the fees for field trips and special activities.

Additional $45.00 per week for AM and/or PM extended care
7:00 AM-9:00 AM _____
4:00 PM-6:00 PM _____

Please check the full week's options below:

_____ **I am enrolling my child for ALL TEN weeks of the summer program.**
_____ **I am enrolling my child for the following full weeks (please circle weeks attending):**

Week 1 (June 17 - 21)	**Week 6 (July 22 - 26)**
Week 2 (June 24 – 28)	**Week 7 (July 29 – August 2)**
Week 3 (July 1 - 5) Closed Thursday, 7/4, Prorated fee	**Week 8 (August 5 - 9)**
Week 4 (July 8 - 12)	**Week 9 (August 12 - 16)**
Week 5 (July 15 - 19)	**Week 10 (August 19 – 23)**

Part Time:
$45.00 per day (minimum 2 days per week)
9:00 AM-4:00 PM _____
*For Camp Hawk 2024 the FRC will cover the fees for field trips and special activities.

Additional $15.00 per day for AM and/or PM extended care
7:00 AM-9:00 AM _____
4:00 PM-6:00 PM _____

For children attending part time, please circle the days attending below:

Week 1 (June 17- 21)	**M T W Th F**	
Week 2 (June 24-28)	**M T W Th F**	
Week 3 (July 1-5)	**M T W ~~Th~~ F**	**(Closed Thursday 7/4 in observance of Independence Day)**
Week 4 (July 8-12)	**M T W Th F**	
Week 5 (July 15-19)	**M T W Th F**	
Week 6 (July 22-26)	**M T W Th F**	
Week 7 (July 29-August 2)	**M T W Th F**	
Week 8 (August 5-9)	**M T W Th F**	
Week 9 (August 12-16)	**M T W Th F**	
Week 10 (August 19-23)	**M T W Th F**	

SUMMER PROGRAM POLICIES:

- Registration fees are non-refundable.
- Registrations will be accepted until June 1, 2024.
- A $100.00 tuition deposit per family is due upon registration. The tuition deposit will be applied to the first week of camp enrollment. The tuition for June, July and August will be due on the first of each month. A $15.00 late fee will be assessed if payment is not received by the 5th of each month.
- Refunds of the tuition deposit will be given only if your child(ren) withdraw **before June 1, 2024**. No tuition deposits will be refunded after this date.
- The tuition for June, July and August will be due on the first of each month. A $15.00 late fee will be assessed if payment is not received by the 5th of each month.
- If requesting to withdraw from any enrolled week at Camp Hawk after June 1, 2024, families **are responsible and required to pay the tuition for all registered weeks**.
- Any change in registration requires a Change of Registration form found on the FRC website.
- The summer program has a limited capacity and will be filled first come first served.
- The Tolland Family Resource Center must have a copy of the child's current health form on file by June 1, 2024.
- Please read our Summer Handbook for all program polices. The handbook will be available on our website (tolland.k12.ct.us/community/family_resource_center) on June 1, 2024.

My child _____ will be attending the summer program at the Tolland Family Resource Center. I have enclosed a non-refundable registration fee of $50.00 per child / $75.00 per family.

I have read and understood the above policies of the School Age Care Summer Camp Program.

Parent Signature: _____Date: _____

Please note: Families will receive a confirmation letter of enrollment. In the event the program is full at the time of your registration, you will receive notification and your check will be returned to you. A waiting list will be kept in the order in which the registrations are received.

Thank you for your registration for the
Family Resource Center School Age Care Summer Camp Program.

For Office Use:
Date received _____
Check #: _____
Amount received _____

FOOD ALLERGY ALERT (FRC)

_____ _____

Child's Full Name Allergic to:

Place recent photo here

Ingestion: YES NO UNKNOWN
Contact: YES NO UNKNOWN
Inhalation: YES NO UNKNOWN

Describe type of reaction:

_____
_____
_____

Medication(s) Prescribed:

_____
_____
_____

State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	❑ Black, not of Hispanic origin
	❑ American Indian/ Alaskan Native	❑ White, not of Hispanic origin
Primary Care Provider	❑ Hispanic/Latino	❑ Asian/Pacific Islander
		❑ Other
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part 1 — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part 1 of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***Speech** (school entry only)	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____
Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped *Provider* Name and Phone Number

HAR-3 REV. 7/2018

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ Yes ❑ No

Risk Assessment	**Describe Risk Factors**	
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____	❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other _____

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____

Signature of Parent/Guardian — Date

_____

Signature of health care provider — DMD / DDS / MD / DO / APRN / PA / RDH — Date Signed — Printed/Stamped ***Provider*** Name and Phone Number

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 7/2018

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Exemption: Religious _____ **Medical:** Permanent _____ Temporary _____ **Date:** _____

Renew Date: _____ _____ _____ _____

Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.
Medical exemptions that are temporary in nature must be renewed annually.

Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped *Provider* Name and Phone Number