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Colorado Department
of Public Health and Environment
and Environment

## <u>NOTICE of Exclusion</u> Immunization Record Needed for School/Child Care Attendance

<u>Note to Health Care Provider</u>: Colorado Statute 6 CCR 1009-2 mandates the establishment of school required vaccines through the authority of the Colorado Board of Health as a requirement for student attendance at Colorado Schools. The "required" schedule closely follows the ACIP/AAP recommended schedule. Please contact the Colorado Immunization Section at 303-692-2650 if you have questions about the school required vaccine requirements. Thank you.

## To the parent/guardian of:

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

## The following shots are needed:

 DTaP (Diphtheria/Tetanus/Pertussis)	Hib (Haemophilus Influenzae type b)
 Tdap (Tetanus/Diphtheria/Pertussis)	PCV13 (Pneumococcal Conjugate)
 Td (Tetanus/Diphtheria)	Hepatitis B
 Polio	Varicella (Chickenpox)
 MMR (Measles/Mumps/Rubella)	

+ All reporting of *Chickenpox* disease is to be documented by a healthcare provider (physician or RN)

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

Signed:				Date:		
School/Childcare:			Phone:		Fax:	
Method of Notification:	_ Phone _	Mail	In Person			

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

VACCINE	HEALTHCARE PROVIDER If you need a referral to a healthcare provider, call 1-800-688-7777.			Ş	DUE TO BE RECEIVED Schedule must follow medically recommended intervals consistent with ACIP, AAP, or the vaccine manufacturer's package insert.						
DTaP	Name		Phone Number	C	Date	Date	Date	Da	te	Date	
Tdap	Name		Phone Number	C	Date	7					
Td	Name		Phone Number	C	Date	Date		Date Da		Date	
Polio	Name		Phone Number	C	Date	Date	e Date			Date	
MMR	Name		Phone Number	C	Date	ate			Date		
Hib	Name		Phone Number	C	Date	Date			Date		
PCV13	Name		Phone Number	C	Date	Date		Date		Date	
Hepatitis B	Name		Phone Number	C	Date		Date		Date		
Varicella	Name		Phone Number	C	Date			Date			

I agree to the above plan for receiving the required shots, submitting the records, and completing the Certificate of Immunization.
Signed: \_\_\_\_\_\_ Date: \_\_\_\_\_\_