



HUBER HEIGHTS CITY SCHOOLS
EXCLUSION NOTICE FROM CLINIC
NOTICE OF INCOMPLETE HEALTH AND/OR
REGISTRATION INFORMATION

900.19A
 5-2-16
 2-part

Student's Name _____ Grade: 7th grade School: Weisenborn

Mark(x) indicates that we do **NOT** have the following health and/or registration information for your child:

HEALTH: State Law 3313.671 lists immunizations required for school attendance.

Please have dates of these vaccines to school before August 29, 2018...or your child will be excluded from attending school.

_____ **HEPATITIS B VACCINATION SERIES** DATES: 1.)_____ 2.)_____ 3.)_____

_____ **DIPHTHERIA, PERTUSSIS, TETANUS, OR TD ADULT VACCINE** (Students receiving all 4 primary immunizing doses of DTP or DtaP prior to their 4th birthday must receive a single booster dose prior to kindergarten entry.)(Beginning 2010, booster Tdap required for 7th grade entrance. Progressive)
 DATES: 1.)_____ 2.)_____ 3.)_____ 4.)_____ 5.)_____ **Tdap. -X**

_____ **OPV OR IPV POLIO VACCINE** (Kindergarten students receiving a third dose of Polio vaccine prior to their 4th birthday must receive a fourth dose.)
 DATES: 1.)_____ 2.)_____ 3.)_____ 4.)_____

_____ **MENINGOCOCCAL DATES:** **1.) -X** 2.)_____ (one dose before 7th, two doses before 12th)

_____ **MMR VACCINE** (The first dose must have been received on or after the first birthday. The second dose must have been received no sooner than 28 days after the first MMR dose.)
 DATES: 1.)_____ 2.)_____

_____ **VARICELLA (Chicken Pox)** (Beginning 2010, 2 vaccines required for kindergarten entrance. Progressive) (one dose required for certain grades) DATE: 1.)_____ 2.)_____

PRE-SCHOOL HEALTH REQUIREMENTS ONLY

_____ **HAEMOPHILUS B (HIB)** (4 doses or one dose administered at or after 15 months of age.)
 DATE: 1.)_____ 2.)_____ 3.)_____ 4.)_____

_____ **HEPATITIS A VACCINATION SERIES** DATES: 1.)_____ 2.)_____

_____ **PNEUMOCOCCAL DATES:** 1.)_____

_____ **FLU DATE:** 1.)_____

_____ **CHILD MEDICAL STATEMENT FOR CHILD CARE**
 DATE: _____

OTHER: _____ **BIRTH CERTIFICATE** _____ **PROOF OF CUSTODY** _____ **PROOF OF RESIDENCY**

PLEASE CALL YOUR CHILD'S DOCTOR OR SCHOOL FOR ANY QUESTIONS.

Sincerely,

Raylaine D. Butler RN-Supervisor Health Services Huber Heights City Schools
Laurie Combs- Weisenborn Clinic Assistant
Laura.combs@huberheightscityschools.org