Tuition Fees 2022-2023
Updated 8/2022

Infant and Toddler:

Full Day: $70.00

Half Day: $45.00

Preschool:

Full Day: $55.00

Half Day: $40.00

Before and After Care:

Before School: $10.00
After School: $20.00
Early Dismissal Days: $40.00

There is an annual **non-refundable,** $75.00 registration fee that is due at the time of registration. The fee for before/aftercare is $35.00 and for families of two or more children is $100.00

Please plan to be punctual when picking up your child. Late charge for parents who pick up after their scheduled pick up time will be $25 per 15 minutes(or any part thereof). Half day participants who pick up more than 15 minutes late will be assessed a fee of $10; 30 minutes late they will be charged the full day rate.

Tuition Policy

Please read the tuition policy carefully. After reading each numbered section, write your initials at the end of the section. This shows that you have read and understand it. If you have any questions, please ask the Executive Director.

1. **Tuition is paid in advance and may be paid weekly, monthly, or quarterly.**
2. **Accounts will become delinquent on the Monday following a missed payment. A 20% late fee will be added to your account each week until the balance is paid in full. Any fees not paid by the following Friday will jeopardize your child's day care slot. The Sharon Day Care Center will take legal action if necessary to collect unpaid tuition. Phone calls will be made on Friday regarding late tuition.**
3. Tuition and fees are non-refundable. Exceptions may be made in case of illness or ten (10) consecutive days or more.
4. With two weeks advance written notice, there will be a 50% reduction in fees for family vacations (**a minimum of 5 consecutive days and a maximum of 2 weeks per year**). If such notice is not received, payment of tuition is due in full.
5. No tuition will be charged for holidays on which the Center is closed. When the Center is closed due to severe weather conditions or any other emergency, a tuition credit (to be applied at the end of the year) will be granted.
6. Parents who withdraw a child from the Center without a week's notice will be required to pay that week's tuition.
7. All prior tuition and fees must be paid in full, before enrollment for the coming year can be allowed.
8. **Pick up should be punctual. If a child is in care after their scheduled pick up time a charge of $25 will be charged for every 15 minutes (or any part there of).**

Tuition Agreement

My child _____ will be enrolled at the Sharon Day Care Center for ___ days at a weekly rate of _____. **I have read the provisions concerning tuition payment and agree to abide by them.** I realize that failure to meet my financial obligations to the Center may result in the dismissal of my child by the Board of Directors

_____ Parent's Signature

_____ Sharon Day Care Director Signature

Date_____

P.O. Box 1031 · Sharon, CT 06069 · (860) 364-5182

Financial Assistance Application

Please complete the following and return the application to _____ as soon as possible. All information is kept confidential.

Date of application_____

Name of Parent/Guardian_____

Address_____

Telephone number_____

Name of Child_____

1. Total income for 20___: _____
   Please include a copy of your_____income tax return. (If both parents are working and filed separately, please include a copy of both returns). Also, include pay stubs from the last 3 weeks of employment/unemployment.

2. Are you presently receiving welfare payments or other government support _____
   If so, in what amount_____

3. Are you receiving child support and/or alimony_____
   If so, in what amount_____

4. Number of people in the family_____

5. Number of people in the household_____

6. Number of children attending Sharon Day Care Center_____

7. Number of children in family_____

8. List weekly payments for other childcare expenses_____

9. Number of days and hours per week child will be attending Sharon Day Care Center _____

Child Schedule & Registration
2022-2023

We as parents or guardians, hereby register our child, _____ at Sharon Day Care Center, according to the schedule found below. We understand that we are responsible for the full day rate of $55.00 and/or half day rate of $40.00 in the Preschool program, and/or the full day rate of $70.00, in the Infant and Toddler program. We will be billed and will pay for services provided on a weekly basis. We understand that there is a minimum of 2 days per week and agree to pay this amount. Any financial assistance obtained or granted will be credited on receipt of funds. The annual registration fee, of $75.00 per child, $100.00 for two or more children, will be billed within the first week of September and is used for curriculum items and enrichment activities. It is non-refundable.

Please choose on of the following drop off/and pick up schedules:

	7:30-4:00	8:00-4:30	8:30-5:00
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

Start date:_____ Child's Birth Date:___/___/___

Parents email: _____

Signature of Parent/Guardian: _____Date:___/___/____

Signature of Director:_____Date:___/___/___

It is a pleasure to enroll your child and we are grateful for your support! The teachers join me in welcoming you to our center!

Best,
Carrie-Ann Olsen-Director

Sharon Day Care Center
Child Schedule & Registration
2022-2023

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Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

Start date:_____ Child's Birth Date:___/___/___

Parents email: _____

Signature of Parent/Guardian: _____Date:___/___/____

Signature of Director:_____Date:___/___/___

It is a pleasure to enroll your child and we are grateful for your support! The teachers join me in welcoming you to our center!

Best,
Carrie-Ann Olsen-Director

P.O Box 1030 | Sharon, CT 06069 | (860) 364-5182

DEVELOPMENTAL HISTORY and BACKGROUND INFORMATION

Child's Name: _____ Date of Birth: _____

Person Completing: _____ Relationship to child: _____

Date Completed: _____

Please tell us about your child:

1. How would you like to receive communications from the Center such as newsletters, updates? (Check those that apply) Email: _____ Center Mail: _____
2. Describe your child's daily schedule: bedtime, naptime, feeding/eating etc:

   _____

   _____

   _____
3. Does your child feed himself/herself?_____ Drink from a cup?_____
4. What foods does your child like to eat? _____
5. Does your child have any food restrictions? (Ex: diary)_____
6. Does your child have a special diet? (ex: vegetarian) _____
7. Does your child have any known food allergies? _____
8. What is your child's bathroom routine? _____
9. What does your child call going to the bathroom? (ex: potty) _____
10. Are you in the process of Toilet Training? _____
11. How does your child tell you that he/she needs to use the bathroom? _____

    _____
12. Does your child need help, verbal prompting, or reminders about going to the bathroom?

    _____
13. How does your child like to be comforted? _____

    _____
14. Does your child have any particular fears? (ex: thunder, dogs, loud noises, the dark)___

    _____
15. What is your child's favorite activity? _____
16. What is your child's favorite song? _____
17. What is your child's favorite book? _____
18. If applicable, how do you handle behavior difficulties at home? _____

    _____

19. Please list any previous child care/schooling experiences your child has had: _____

    _____

20. What experiences or skills do you hope your child will gain at the Center? _____

    _____

21. What holidays do you celebrate? (if any) _____

    _____

22. Does your child nap at home? _____ For how long? _____
23. **For infants only** How many naps would you like your child to take? At what time? ___

    _____

24. What does your child nap with? (please provide these items for rest time) _____

    _____

25. What routine do you perform at home before putting your child to sleep? (ex: rocking, singing, reading) _____

    _____

26. Does your child enjoy looking at books? _____
27. Do you have children's books available in the child's home language? _____
28. Where was your child born?_____
29. What countries are most important to your family's cultural background? _____

    _____

30. Are you interested in sharing your cultural background or other interests with the children at SDC by reading stories, sharing games, songs, food, or arts and craft projects? If yes, what would you like to share and when is the best day and time for you? _____

    _____

31. Is there anything else you feel is important for us to know about your child, your child's family or culture? _____

    _____

32. Is there anybody else who regularly cares for your child? Who? _____

    _____

33. What is Parent 1's job/profession? _____
34. What are Parent 1's hobbies? _____
35. What is Parent 2's job/professions? _____
36. What are Parent 2's hobbies? _____
37. Is either parent interested in chaperoning field trips? _____
38. Is either parent interested in joining the Board of Directors? _____
39. Is there anything else we should know about your child? _____

    _____

    _____

Thank you for providing information about your child. It is our intention to make your child feel comfortable while in our care.

Calendar of Closings 2022-2023

August 22-26	**Shut-down**
September 5	**Labor Day**
November 23rd	**Closing at 1:00 PM**
November 24-25	**Thanksgiving Break**
December 26-January 1st	**Holiday Break**
April 7th	**Good Friday**
May 29	**Memorial Day**
June	**Days following Region 1's last day of school.**
July 4	**Fourth of July**
August	**The week before Region 1 opens**

**Please note that this calendar is subject to change, as much advance notice as possible will be given in such cases. Other events will be planned and information posted throughout the year such as Open House, Fundraisers, Family Events,etc.

Please be aware of our inclement weather policy, we follow the Region 1 school district for closing and delays. If Region 1 is closed, the center will also be closed. If Region 1 has a 90 minute delay we will also have a 90 minute delay. Notifications will be on WFSB and wfsb.com, Seesaw and via email.

EMERGENCY INFORMATION CARD

Doctor _____

Address _____

_____

Phone _____

Child's Name _____ Nickname _____

Birthdate _____ Address _____

Home Phone _____ Cell Phone _____

Parent 1 Name _____Address (If Different) _____

Parent 1 Employer _____Phone _____ Work Hours _____

Parent 2 Name _____Address (If Different) _____

Parent 2 Employer _____Phone _____ Work Hours _____

IN EMERGENCY Call _____Phone _____Relaionship _____

Child's Arrival _____ A.M. Departure _____ P.M.

Authorized to pick up child _____

ALLERGIES _____

SPECIAL NOTES (WRITE IN RED) Physical Problems _____

SUNSCREEN AND BUG REPELLANT PERMISSION

Please apply sunscreen before drop-off daily. Additional sunscreen and/or bug repellant will be applied by your child's teacher in the afternoon, if necessary. Please label the sunscreen and bug repellant with your child's name. Thank you!

Child's Name_____

I give the Sharon Day Care Center Staff permission to apply the sunscreen and bug repellant I provide to my child named above. I have labeled the sunscreen and bug repellant with my child's name.

Parent/Guardian Signature_____

Date _____

Photo Release Form

Photographs of the children at Sharon Day Care are used in many areas/venues. We love to display photographs of our daily activities on the walls, for special projects and occasionally place photos in local papers for our family, friends, and community to see. Please indicate below when you would be willing for us to take or display a photo of your child.

- ☐ For classroom photo album, bulletin boards, school-made books, etc.
- ☐ During birthday parties, special events at the center, etc.
- ☐ For publications, advertising, website, and/or public relations
- ☐ For educational workshops and presentations
- ☐ For parent/teacher conferences, special parent projects

I/We hereby give consent to Sharon Day Care to use my child's photograph (motion or still) for the above designated purposes.

Child's Name_____

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____

DIRECTORY PERMISSION

Yes, I want my name, mailing address, child's name, phone number and email address included in the SDC Directory. THis list will be available to all other parents at Sharon Day Care Center.

Child's Name _____

Parent Name _____

Parent Signature _____ Date _____

ALLERGY POSTING PERMISSION

If your child has an allergy, please sign below giving Sharon Day Care Center permission to post your child's name and allergy in classrooms near meal preparation areas and programs areas.

Child's Name _____ Allergy _____

Parent Name _____

Parent Signature _____ Date _____

PERMISSION TO LEAVE DAYCARE CENTER PROPERTY

Yes, I give permission for _____ to leave the enclosed play yard and go onto the basketball court, the soccer field, to ride trikes/bikes on the paved area and to take nature walks and stroller rides with their teachers.

This is a blanket permission slip for August _____ to August _____ for any day when my child is in attendance.

Child's Name _____
Parent Name _____
Parent Signature _____ Date _____

CHILD ENROLLMENT & EMERGENCY MEDICAL CARE FORM

Date of Application: _____ Date of Enrollment: _____ Last Day of Enrollment: _____
Child's Name: _____ Child's Date of Birth: _____
Child's Address: _____ City: _____ Zip Code _____
Mother's Name: _____Address: _____
City: _____ Zip Code: _____e-mail Address: _____
Home Telephone #: (_____) _____ Cell #: (_____) _____
Mother's Employer: _____ Work #: (_____) _____
Mother's Employer Address: _____ City: _____ Zip Code _____
Father's Name: _____Address: _____
City: _____ Zip Code: _____e-mail Address: _____
Home Telephone #: (_____) _____ Cell #: (_____) _____
Father's Employer: _____ Work #: (_____) _____
Father's Employer Address: _____ City: _____ Zip Code _____

****

Weekly Care Schedule: (please include the child's hours in care for each day)
Sunday: _____
Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____

Persons permitted to remove the child from the child care program on behalf of parent. (Use back for additional names.)
Name: _____
Phone #: _____Relationship _____

****

In an emergency, adults to be contacted if parent cannot be reached and to whom the child can be released.
(Use back for additional names.)
Name: _____
Phone #: _____Relationship _____

****

Medical Information

Known Allergies: _____ Last Tetanus: _____
Insurance Carrier: _____ Insurance ID: _____

Child's Physician: Name: _____ Phone #: (_____) _____
Address _____ City:_____ Zip Code: _____
Child's Dentist: Name: _____ Phone #: (_____) _____
Address _____ City:_____ Zip Code: _____

****

Emergency Authorization

I give my consent for the First Aid and CPR certified staff of **(program's name)** _____, to administer first aid and CPR to my child and to contact the above named physician or dentist if my child has a medical emergency. I also give my consent for my child to be transported to the nearest hospital in the event of a medical emergency. I will be responsible for all medical fees.
Preferred Medical Facility: _____

****

Behavior Management and Parent Handbook

I acknowledge that I have read the parent handbook and agree to abide by the policies contained in it and that the techniques used to manage child behaviors in the facility have been discussed with me prior to enrollment.

Signature of Parent or Guardian: _____ **Date**: _____

Signature of Parent or Guardian: _____ **Date**: _____

Parent/Guardian Authorization for the Administration of
Non-Prescription Topical Medications by Child Care Personnel

To Child Care Personnel:

I hereby request that the following non-prescription topical medications be administered to my child by a child care staff member of the _____.
(Name of child day care program)
I understand that I must supply the child care program with the non-prescription topical medication in the original container labeled with the child's name, name of the medication, and the directions of the medication administration.

This authorization is limited to the following topical medications:
1. Diaper changing or other ointments free of antibiotic, antifungal or steroidal medications
2. Medicated powders
3. Teething, gum, or lip medications

Name of Child:_____Date of Birth:_____

Address:_____

Name of Medication:_____

Schedule of Administration:_____

Site of Administration:_____

Reason medication is being administered:_____

Medication shall be administered from:_____ to:_____

Name of Parent/Guardian_____ Date:_____

I have administered at least one dose of the above medication to my child without adverse side effects.

Signature:_____ Relationship to child:_____

Address:_____ Telephone:_____

Staff to complete:

Parent authorization form and medication received by:_____
(Signature of staff)
Medication Started:_____(date and time)
Medication Ended:_____(date and time)

Parent permission and medication administration record shall become part of the child's health record when the medication has ended.

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone / Cell Phone	
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N Does your child have dental insurance? Y N Does your child have HUSKY insurance? Y N	If your child does not have health insurance, call **1-877-CT-HUSKY**	

* If applicable

Part I — 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	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name _____ Birth Date _____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

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

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT_____in/cm_____% *Weight_____lbs._____oz /_____% BMI____/____% *HC_____in/cm_____% (Birth – 24 months) *Blood Pressure_____/____ (Annually at 3 – 5 years)

Screenings

*Vision Screening
❑ EPSDT Subjective Screen Completed (Birth to 3 yrs)
❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

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

❑ Unable to assess
❑ Referral made to: _____

*Hearing Screening
❑ EPSDT Subjective Screen Completed (Birth to 4 yrs)
❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

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

❑ Unable to assess
❑ Referral made to: _____

*Anemia: at 9 to 12 months and 2 years

*Hgb/Hct: | *Date

*Lead: at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5µg/dL ❑ No ❑ Yes

*TB: High-risk group? ❑ No ❑
Yes Test done: ❑ No ❑ Yes Date: _____
Results: _____
Treatment: _____

*Dental Concerns ❑ No ❑ Yes
❑ Referral made to: _____
Has this child received dental care in the last 6 months? ❑ No ❑ Yes

*Result/Level: *Date

Other:

*Developmental Assessment: (Birth – 5 years) ❑ No ❑ Yes **Type:**

Results:

*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 an **Asthma Action Plan***
❑ Rescue medication required in child care setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: _____
Epi Pen required: ❑ No ❑ Yes
History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II
Seizures ❑ No ❑ Yes: Type: _____

Other Chronic Disease: _____

❑ This child has the following problems which may adversely affect his or her educational experience:
❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior
❑ This child has a developmental delay/disability that may require intervention at the program.
❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

❑ No ❑ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
❑ No ❑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
❑ No ❑ Yes This child may fully participate in the program.
❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

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

Child's Name: _____ **Birth Date:** _____ REV. 3/2015

Immunization Record

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

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Influenza						
Tdap/Td						

Disease history for varicella (chickenpox) _____
(Date) (Confirmed by)

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

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born on or after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

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