NYC | Department of Health and Mental Hygiene | Department of Education

Cheryl Lawrence, MD, FAAP
Medical Director

Office of School Health
42-09 28th St.
Queens, NY 11101-4132

July 2020

Dear Parent or Guardian,

New York City has updated the school immunization requirements for the 2020-2021 school year. A list of these requirements for 2020-2021 is included with this letter. Before the school year begins, you must submit proof of immunization for your child if they are attending child care or school.

All students in child care through grade 12 must meet the requirements for:

- The DTaP (diphtheria-tetanus-pertussis), poliovirus, MMR (measles-mumps-rubella), varicella and hepatitis B vaccines.

Children under age 5 who are enrolled in child care and pre-kindergarten (pre-K) must also meet the requirements for:

- The Hib (*Haemophilus influenza* type b) and PCV (pneumococcal conjugate) vaccines.
- The influenza (flu) vaccine: Children must receive the flu vaccine by December 30, 2020 (preferably, when it becomes available in early fall).

Children in grades 6 through 12 must also meet the requirements for:

- The Tdap booster and MenACWY (meningococcal conjugate) vaccines.

Please review your child's immunization history with your child's health care provider. Their provider can tell you whether additional doses of one or more vaccines are required for your child to attend child care or school this year.

If you have questions about these 2020-2021 requirements, please contact your child care center or school's administrative office.

Sincerely,

Cheryl Lawrence

Cheryl Lawrence, MD, FAAP
Medical Director
Office of School Health

Is Your Child Ready for Child Care or School?

2020-2021 School Year

Learn about required vaccinations in New York City.

All students ages 2 months to 18 years in New York City must get the following vaccinations to go to child care or school. Review your child's vaccine needs based on their grade level this school year.

VACCINATIONS	Pre-Kindergarten (Child Care, Head Start, Nursery, 3K or Pre-k)	Kindergarten – Grade 5	Grades 6 – 11	Grade 12
Diphtheria, tetanus and pertussis (DTaP)	4 doses	5 doses or 4 doses ONLY if the fourth dose was received at age 4 years or older or 3 doses ONLY if the child is 7 years or older and the series was started at age 1 year or older	3 doses	
Tetanus, diphtheria and pertussis booster (Tdap)			1 dose (at or after age 11 years)	
Polio (IPV or OPV)	3 doses	4 doses or 3 doses if the third dose was received at age 4 years or older		
Measles, mumps and rubella (MMR)	1 dose	2 doses		
Hepatitis B	3 doses	3 doses	3 doses or 2 doses of adult Hepatitis B vaccine (Recombivax HB) if the doses were received at least 4 months apart between the ages of 11 and 15 years	
Varicella (chickenpox)	1 dose	2 doses		
Meningococcal conjugate (MenACWY)			Grade 6: Not applicable Grades 7 – 11 = 1 dose	2 doses or 1 dose ONLY if the first dose was received at age 16 years or older
Haemophilus influenzae type B conjugate (Hib)	1 to 4 doses Depends on child's age and doses previously received			
Pneumococcal conjugate (PCV)	1 to 4 doses Depends on child's age and doses previously received			
Influenza	1 dose			

The number of vaccine doses your child needs may vary based on age and previous vaccine doses received. Your child may need additional vaccines or vaccine doses if they have certain health conditions. Talk to your health care provider if you have questions. For more information, call **311** or visit **nyc.gov/health** and search for **student vaccines.**

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CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth (Month/Day/Year) ___/___/___

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

City/Borough | State | Zip Code | School/Center/Camp Name | District Number | Phone Numbers: Home / Cell / Work

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name | Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs)

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs (list) _____

☐ Foods (list) _____

☐ Other (list) _____

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma (***check severity and attach MAF***): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis ☐ Seizure disorder

☐ Behavioral/mental health disorder ☐ Speech, hearing, or visual impairment

☐ Congenital or acquired heart disorder ☐ Tuberculosis (*latent infection or disease*)

☐ Developmental/learning problem ☐ Hospitalization

☐ Diabetes (***attach MAF***) ☐ Surgery

☐ Orthopedic injury/disability ☐ Other (specify) _____

Explain all checked items above. ☐ ***Addendum attached.***

Medications (*attach MAF if in-school medication needed*)

☐ None ☐ Yes (*list below*)

_____

_____

_____

_____

PHYSICAL EXAM Date of Exam: ___/___/___

Height _____ cm (___ ___ %ile)

Weight _____ kg (___ ___ %ile)

BMI _____ kg/m² (___ ___ %ile)

Head Circumference (age ≤2 yrs) _____ cm (___ ___ %ile)

Blood Pressure (age ≥3 yrs) _____ / _____

General Appearance:

☐ Physical Exam WNL

	Nl	Abnl
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐

Describe abnormalities:

DEVELOPMENTAL (age 0-6 yrs)

Validated Screening Tool Used? ☐ Yes ☐ No | Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help

☐ Communication/Language ☐ Gross Motor/Fine Motor

☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< **1 year** ☐ Breastfed ☐ Formula ☐ Both

≥ **1 year** ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes (*list below*)

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) (*required at age 1 yr and 2 yrs and for those at risk*)	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment (*annually, age 6 mo-6 yrs*)	___/___/___	☐ At risk (*do BLL*) ☐ Not at risk
— Child Care Only —		
Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing

	Date Done	Results
< 4 years: gross hearing	___/___/___	☐Nl ☐Abnl ☐Re
OAE	___/___/___	☐Nl ☐Abnl ☐Re
≥ 4 yrs: pure tone audiometry	___/___/___	☐Nl ☐Abnl ☐Re

Vision

	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ Nl ☐ Abn
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to te
Screened with Glasses?		☐ Yes ☐ N
Strabismus?		☐ Yes ☐ N

Dental

Visible Tooth Decay	☐ Yes
Urgent need for dental referral (*pain, swelling, infection*)	☐ Yes
Dental Visit within the past 12 months	☐ Yes

CIR Number | ☐ Physician Confirmed History of Varicella Infection | Report only positive immu

IMMUNIZATIONS – DATES

										IgG Titers	Date
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___	Hepatitis B	___/___/
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___	Measles	___/___/
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Varicella	___/___/___	___/___/___	Mumps	___/___/
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening ACWY	___/___/___	___/___/___	Rubella	___/___/
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hep A	___/___/___	___/___/___	Varicella	___/___/
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Rotavirus	___/___/___	___/___/___	Polio 1	___/___/
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening B	___/___/___	___/___/___	Polio 2	___/___/
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Other _____	___/___/___	___/___/___	Polio 3	___/___/

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** (*list*) **ICD-10 Code**

_____ _____

_____ _____

_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (*specify*) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | Date Form Completed ___/___/___

DOHMH ONLY PRACTITIONER I.D.

Health Care Practitioner Name and Degree (*print*) | Practitioner License No. and State

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Y

Comments:

Facility Name | National Provider Identifier (NPI)

Date Reviewed: ___/___/___ | **I.D. NUMBER**

REVIEWER:

Address | City | State | Zip

Telephone | Fax | Email

FORM ID#