

# 2018-2019 Missouri School Immunization Requirements

- All students must present documentation of up-to-date immunization status, including month, day, and year of each immunization before attending school.
- The Advisory Committee on Immunization Practices (ACIP) allows a 4-day grace period. Students in all grade levels may receive immunizations up to four days before the due date.
- Required immunizations should be administered according to the current Advisory Committee on Immunization Practices Schedule, including all spacing, (<http://www.cdc.gov/vaccines/schedules/index.html>).
- To remain in school, students "in progress" must have an Immunization In Progress form (Imm.P.14) on file. In progress means that a child has begun the vaccine series and has an appointment for the next dose. This appointment must be kept and an updated record provided to the school. If the appointment is not kept, the child is no longer in progress and is noncompliant. (i.e., Hep B vaccine series was started but the child is not yet eligible to receive the next dose in the series.)
- Religious (Imm.P.11A) and Medical (Imm.P.12) exemptions are allowed. The appropriate exemption card must be on file. Unimmunized children are subject to exclusion from school when outbreaks of vaccine-preventable diseases occur.

Vaccines Required for School Attendance	Dose Required by Grade												
	K	1	2	3	4	5	6	7	8	9	10	11	12
DTaP/DTP/DT <sup>1</sup>	4+	4+	4+	4+	4+	4+	4+	4+	4+	4+	4+	4+	4+
Tdap <sup>2</sup>									1	1	1	1	1
MCV <sup>3</sup> (Meningococcal Conjugate)									1	1	1		2
IPV (Polio) <sup>4</sup>	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
MMR <sup>5</sup>	2	2	2	2	2	2	2	2	2	2	2	2	2
Hepatitis B <sup>6</sup>	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Varicella <sup>7</sup>	2	2	2	2	2	2	2	2	2	1	1	1	1

1. Last dose on or after the fourth birthday and the last dose of pediatric pertussis before the seventh birthday.  
**Maximum needed:** six doses.
2. 8-12 Grades: Tdap, which contains pertussis vaccine, is required.
3. Grade 8-10: One dose of MCV is required. Dose must be given after 10 years of age.  
Grade 12: Two doses of MCV are required unless the first dose was administered to a student who was 16 years of age or older, in which case only one dose is required. At least one dose must be given after 16 years of age.
4. Kindergarten-8 Grade: Last dose must be administered on or after the fourth birthday. The interval between the next-to-last and last dose should be at least six months.  
9-12 Grades: Last dose on or after the fourth birthday. Any combination of four doses of IPV and OPV constitutes a complete series. **Maximum needed:** four doses.
5. First dose must be given on or after twelve months of age.
6. There must be at least four weeks between dose one and two; at least 8 weeks between dose two and three; at least 16 weeks between doses one and three and final dose must be given no earlier than 24 weeks of age.
7. First dose must be given on or after twelve months of age.  
Kindergarten-8 Grade: As satisfactory evidence of disease, a licensed health care provider may sign and place on file with the school a written statement documenting the month and year of previous varicella (chickenpox) disease.  
9-12 Grades: As satisfactory evidence of disease, a parent/guardian or MD or DO may sign and place on file with the school a written statement documenting the month and year of previous varicella (chickenpox) disease.



## Physical Examination Form

In accordance with the recommendations of the Saint Louis Archdiocese Health Advisory Committee, all children are expected to have a complete physical examination upon entrance to preschool, prekindergarten, kindergarten, 3<sup>rd</sup> grade, 6<sup>th</sup> grade, 9<sup>th</sup> grade, and all newly enrolled students who have not had a physical examination within the past twelve (12) months. The physical examination must be completed and signed by a medical doctor or physician assistant/nurse practitioner working under a collaborative practice agreement with a medical doctor. This form is provided for the convenience of your child's physician. At the time of the examination, please have your physician complete and sign this form. It is expected that each student have this form on file at school by the first day of school

School: St. Francis Borgia Grade School Grade: \_\_\_\_\_

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_ M or F \_\_\_\_\_

Date of Examination \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_ BMI \_\_\_\_\_

### General Appearance

Nutrition \_\_\_\_\_ Nose \_\_\_\_\_ Abdomen \_\_\_\_\_ Skin \_\_\_\_\_ Mouth \_\_\_\_\_ Back \_\_\_\_\_ Lungs \_\_\_\_\_

Genitalia \_\_\_\_\_ Head \_\_\_\_\_ Throat \_\_\_\_\_ Extremities \_\_\_\_\_ Heart \_\_\_\_\_ Neck \_\_\_\_\_ Eyes \_\_\_\_\_

Neurologic Exam \_\_\_\_\_

Please list any allergies \_\_\_\_\_

Physician Comments & Recommendations (give details of management of significant illnesses)

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Can student carry a full program of school work? Yes No (circle one)

Should physical activity be restricted? Yes No

Explain \_\_\_\_\_

Hearing Test: Type of test \_\_\_\_\_ R L Both

Vision Test: Type of test \_\_\_\_\_ R L Both

Physicians Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Physicians Name \_\_\_\_\_

Office Stamp

**Please Attach a Copy of the Current Immunization Record.**

**Please Attach a Copy of any action plans regarding allergies and other medical conditions.**

**PHYSICIAN AUTHORIZATION FOR  
OVER THE COUNTER MEDICATIONS**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_  
Street City/State/ZIP

Name of Licensed Prescriber \_\_\_\_\_ Title \_\_\_\_\_

Doctor's Telephone # \_\_\_\_\_

I HAVE DETERMINED THAT IT IS NECESSARY FOR THIS MEDICATION TO BE ADMINISTERED DURNING SCHOOL HOURS AS PER PARENT/GUARDIAN INSTRUCTIONS.

Please circle the medications that may be given at school. Medications will be given as per product instructions:

Acetaminophen: child/adult	Cough syrup	Advil: child/adult
Antibiotic ointment	Sinus tablets	Aleve: child/adult
Cough drops	Benadryl cream	Benadryl liquid/tablets
Ibuprofen	Burn gel	Chap Stick
Motrin: child/adult	Saline solution	
Tums	Calamine lotion	
Other: _____		

Other specific directions or information regarding this medication administration:

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Specific side effects, contraindications or possible adverse reaction to be observed:

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\_\_\_\_\_  
Signature of licensed prescriber

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date