DEPARTMENT OF DEFENSE
EDUCATION ACTIVITY
4040 NORTH FAIRFAX DRIVE
ARLINGTON, VIRGINIA 22203-1635

DoDEA Immunization Requirements
November 2011

Students who enroll in DoDEA schools are required to meet specific immunization requirements. These requirements represent the minimum requirements and do not necessarily reflect the optimal immunization status for students. This copy of *DoDEA Immunization Requirements* is provided to parents for informational purposes only. Official proof of immunization must be provided to school officials at the time of initial registration and upon request of school officials to verify immunization compliance i.e., copy of child's immunization/shot record.

The immunizations noted below are for students who are age five years old and older. For students who are under the age of five years, immunization compliance is based on the age appropriate immunization schedule established by the Advisory Committee on Immunization Practices (ACIP).

IMMUNIZATION	**MINIMUN DoDEA REQUIREMENT FOR SCHOOL ATTENDANCE**
+ Diphtheria, Tetanus, Pertussis DTaP, DT Tdap	* DTaP, DT series completed by age 4 years or on schedule for completion. If the fourth dose of DTaP, DT was administered before the fourth birthday, a booster (fifth) dose is required for initial school entry. * Tdap required at age 11 years old.
+ Hepatitis A	* Series completed prior to initial entry into school or on schedule for completion.
+ Hepatitis B	* Series completed prior to initial entry into school or on schedule for completion.
+ Measles, Mumps, Rubella	* Series completed prior to initial entry into school or on schedule for completion.
Meningococcal	* Series initiated at age 11 years. Booster at age 16 years.
+ Polio	* Series completed by age 4 years or on schedule for completion. If the fourth dose of Polio was administered before the fourth birthday, an additional dose is required for initial school entry.
+ Varicella	* Series completed prior to initial entry into school or on schedule for completion.
Tuberculosis	Routine testing is no longer necessary unless risk factors are identified as determined by local medical command.
Influenza	Requirement determined by local medical command.

Information on immunizations and dosage scheduling provided by the Advisory Committee on Immunization Practices http://www.cdc.gov/vaccines/recs/acip, the American Academy of Pediatrics, http://aap.org, and the American Academy of Family Physicians http://aafp.org.

As of July 2010, DoDEA aligned with the immunization guidance prescribed by the Interstate Compact on Educational Opportunity for Military Children. As a result, provision has been made for students transferring to a new location allowing up to 30 calendar-days after enrollment to obtain any immunization(s) required by the receiving state. For a series of immunizations, initial vaccination must be obtained within 30 days of initial enrollment.

+ May be administered in additional combination vaccines.
* Series dose spacing based on immunization schedule for persons aged 4 through 18 years.

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
IMMUNIZATION REQUIREMENTS

To enroll in DoDEA schools students MUST meet specific immunization requirements. For details: See DoDEA Immunization Requirements, November, 2011. This form is provided to parents to assist with immunization documentation. Medical proof of immunizations must be completed by medical authority and provided to the school officials at the time of initial registration. Medical authorities must sign and stamp their form of choice indicating that immunization records have been reviewed and that the minimum DoDEA requirements are met. At time of registration, copies of prior immunization administration records may be requested to supplement information provided by medical authorities.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. section, 2164 and 20 U.S.C. sections 921-932.
PRINCIPAL PURPOSE: To obtain immunization information needed to enroll students in Department of Defense Education Activity (DoDEA) schools and programs and to promote a safe school environment.
ROUTINES USE(S): DoDEA may release information without prior consent within the DoD when needed to perform an official DoD duty, in accordance with 5 U.S.C. section 552a(b)(1). DoDEA also may release information outside the DoD, in accordance with 5 U.S.C. section 552a(b) (2-12), and the "Blanket Routine Uses," published at http://www.defenselink.mil/privacy/notice/osd. Examples of release may include for valid medical, law enforcement or security purposes, or for use in litigation involving the DoD.
DISCLOSURE: Disclosure to the Agency of the information requested on this form is voluntary; but failure to provide all requested information may result in the delay or denial of student enrollment and services.

Name *(Last, First, Middle Initial)* | **Date of Birth** *(mm/dd/yyyy)*

IMMUNIZATION	DOSE AND DATE GIVEN				
	1 (mm/dd/yyyy)	2 (mm/dd/yyyy)	3 (mm/dd/yyyy)	4 (mm/dd/yyyy)	5 (mm/dd/yyyy)
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis A					
Hepatitis B					
Measles, Mumps, Rubella					
Measles					
Mumps					
Rubella					
Meningococcal					
Polio					
Tetanus, Diphtheria, Pertussis (Tdap)					
Varicella					
Varicella (History of disease.)					
Influenza (Annual)					
PPD	Date Placed:	Date read:	Result: NEG_____mm POS _____mm	MD clearance: YES ☐ NO ☐	BCG

I certify that the minimum immunization requirements have been completed, and or initiated. Immunizations are current until _____

when _____ **immunization(s) is/are due.** **(Date)**

_____
Signature and Stamp of Medical Authority / Date

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
STUDENT HEALTH HISTORY

PRIVACY ACT STATEMENT:

AUTHORITY: 10 U.S.C. sections 2164 and 20 U.S.C. sections 921-932.
PRINCIPAL PURPOSE: To obtain health information about a student enrolling in Department of Defense Education Activity (DoDEA) schools and programs to protect and enhance student health and to promote a safe school environment.
ROUTINE USES: DoDEA may release information without prior consent within the DoD when needed to perform an official DoD duty, in accordance with 5 U.S.C. section 552a(b)(1). DoDEA also may release information outside the DoD, in accordance with 5 U.S.C. section 552a(b)(2-12), and the "Blanket Routine Uses," published at http://www.defenselink.mil/privacy/notice/osd. Examples of release may include for valid medical, law enforcement or security purposes, or for use in litigation involving the DoD.
DISCLOSURE: Disclosure to the Agency of the information requested on this form is voluntary; but failure to provide all requested information may result in the delay or denial of student services.

NAME *(Last, First, Middle Initial)*

Check: ☐ Female ☐ Male

Date of Birth: ____/____/____ (mm / dd / yyyy)

MEDICAL HISTORY: CHECK (✓) ALL THAT APPLY AND EXPLAIN BELOW OR ATTACH ADDITIONAL PAGE(S).

VISION
- ☐ Wears glasses for reading
- ☐ Wears glasses full time
- ☐ Wears contacts
- ☐ Color deficiency
- Other

HEARING
- ☐ Frequent ear infections
- ☐ Ear tubes
  Insertion date:
  Are tubes currently in place:
  Right? YES ☐ NO ☐
  Left? YES ☐ NO ☐
- ☐ Hearing loss: Right ☐ Left ☐
- Other

ENDOCRINE
- ☐ Diabetes
- Other

DERMATOLOGY
- ☐ Eczema
- Other

GENITOURINARY
- ☐ Bladder control problems
- ☐ Urinary track infections
- Other

RESPIRATORY
- ☐ Bronchitis
- ☐ Cystic fibrosis
- ☐ Sinusitis
- Other

CARDIOVASCULAR
- ☐ Sickle cell disorder
- ☐ Heart murmur
- ☐ Hemophilia/Other Bleeding disorders
- ☐ Rheumatoid heart disease
- Other

MUSCULOSKELETAL
- ☐ Muscular Dystrophy
- ☐ Scoliosis
- Other

GASTROINTESTINAL
- ☐ Hernia
- Other

DENTAL
- ☐ Braces
- Other

ASTHMA
Date of Diagnosis:
Inhaler needed:
@ school * YES ☐ NO ☐
@ home YES ☐ NO ☐

PSYCHIATRY
- ☐ Anorexia
- ☐ Bulimia
- ☐ Autism
- ☐ ADD/ADHD
- ☐ Depression
- ☐ Substance abuse history
- ☐ Suicidal
- Other

NEUROLOGICAL
- ☐ Cerebral Palsy
- ☐ Frequent headaches
- ☐ Migraines
- ☐ Spina Bifida
- ☐ Seizures
- ☐ Sleep disorder
- ☐ Other

ALLERGIES (A SHSG Form H-3-7 should be completed.)
- ☐ Bee sting
- ☐ Wasp sting
- ☐ Other insects
- ☐ Seasonal
- ☐ Environmental
- ☐ Food
- ☐ Lactose intolerance (The school will need a letter from the doctor stating that the student is lactose intolerant.)

PROCEDURES: (A SHSG Form H-4-9 should be completed.)
- ☐ My child will/may require special health care procedures during the school day. (See page 2.)

RESTRICTIONS
- ☐ My child has a condition that warrants restriction of activities during school hours. (See page 2)

- ☐ My child takes daily medication at home.
- ☐ My child will need medications during school hours. (* See page 2.)
- ☐ My child may need emergency medications during school hours. (* See page 2.)

* **MEDICATIONS DURING SCHOOL HOURS:** SHSG: H-3-2, 3-3 and/or 3-8 forms must be signed by the physician and a parent; and must accompany prescribed medications that are to be given during school hours. The medication will be in the original container properly labeled by the physician or pharmacy. All medications will remain at school for the duration of the prescription.

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
STUDENT HEALTH HISTORY

Explain any of the above here or attach additional pages.

Identify any special health care procedures that your child may require during the school day:

Identify any condition that warrants a restriction of student activity, specify the nature and duration of the limitation and any other information that would help the school assist your child:

Identify any condition that warrants daily and/or emergency administration of medicine for your child and list those medications:

Parent/Sponsor's Signature:	Primary phone #:	Date:

DEPARTMENT OF DEFENSE
DEPENDENTS SCHOOLS
OFFICE OF THE PRINCIPAL

SY 20_ _ /20_ _ **GRADE _____**

MEDICAL POWER OF ATTORNEY

In the event that my dependent_____(Print Name), is injured or becomes ill, necessitating immediate medical examination or care, while under the supervision or while participating in any activities sponsored by DGF HIGH SCHOOL, PSC 819 BOX 63, FPO AE 09645, I authorize and release to any agent or employee of DGF HIGH SCHOOL, Rota, Spain, to take my dependent to any U.S. military facility or any civilian hospital if deemed necessary by the above referenced individual.

I understand that the above named personnel of DGF High School will use all diligent and reasonable efforts to contact my spouse or me. If personnel of DGF High School or the U.S. treatment facility can contact neither my spouse nor me after reasonable attempts, I authorize and release any physician or other qualified medical personnel to examine my child. I authorize any and all emergency care necessary for treating injuries or illness involving immediate danger of life or limb of my dependent. I further authorize non-emergency care necessary treatment such as suturing superficial lacerations, treating colds, minor allergies and minor gastro-intestinal upsets, splinting sprains, casting uncomplicated fractures, or other similar treatments.

MEDICAL INFORMATION ABOUT THE ABOVE NAMED DEPENDENT
(to be completed by parent)

My dependent has the following medical problems (such as diabetes, seizures, asthma, heart and kidney disease):

_____

_____

My dependent is allergic to the following:

_____

_____

_____

My dependent takes the following medications on a regular and/or "as needed" basis (list name, amount, and purpose of each medication):

_____

_____

_____

Date of last tetanus booster: _____

EMERGENCY CONTACT INFORMATION (to be completed by parent)

Sponsor's Home Address: _____

Home Phone #: _____

Sponsor's Name: _____ Rank: _____

Sponsor's Unit: _____ Work Phone #: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Other Names and Phone Numbers to Use in Case of Emergency if Parents are Unavailable:

_____

_____

_____

Additional Comments:

_____

_____

_____

I AGREE TO NOTIFY THE SCHOOL IMMEDIATELY OF ANY CHANGES IN THE ABOVE INFORMATION.

Date: _____ Signature of Parent: _____

Medical Record Social Security Number: _____

Student's Social Security Number: _____

Are you a Civilian "Pay Patient"? _____ Yes _____ No

PRIVACY ACT NOTICE: AUTHORITY: Title V, Sec. 301. PRINCIPAL PURPOSE: To refer to emergency medical facilities in parents' absence. ROUTINE USES: (a) To obtain emergency medical care when parents cannot be reached; (b) To provide emergency contact names; (c) To supply health and medical information about student. This form is used by DoDDS employees and trained medical personnel in emergency. Social Security number of sponsor is required by military medical facilities in case of emergency referral. MANDATORY/VOLUNTARY DISCLOSURE/EFFECT OF NON-DISCLOSURE: Mandatory. School personnel will not be able to provide emergency care and health services in parents' absence.