NOTICE OF REQUIREMENTS FOR SCHOOL ATTENDANCE: 2020 – 21 NC HEALTH ASSESSMENT AND IMMUNIZATIONS (rev. 1/27/2020)

Physical Exam/Health Assessments: Parents/guardians must submit a completed NC Health Assessment Transmittal Form for each child who is presented for admission to a N.C. public school for the first time unless there is a written religious exemption on file. The Health Assessment may be no more than 12 months old at the time of program entry. (General Statute 130A-440; 10A NCAC09.3005)

Immunizations/Vaccines: For school attendance, parents/guardians must ensure that their child has received the required immunizations at the age required by law unless there is a written medical or religious exemption on file. (General Statute 130A-152-157)

2020-21 Immunization Requirements by Grade

This table provides general information about school immunization requirements. ***Some immunizations require exact spacing between doses or age requirements that are not noted here.*** If you have questions, contact your doctor's office or the nurse at the school where your child will attend.

See N.C. Administrative Code 10A NCAC 41A.0401 for details.

Pre-K	**Grades K – 6**
4 DTP/DTaP/DT	5 DTP/DTaP/DT/Td
3 Polio	4 Polio (Note: 4th dose on or after 4th birthday as of 7/1/15)
1 - 4 Hib (Note: Dose # depends on vaccine type and age when vaccinated)	1 - 4 Hib (Note: Dose # depends on vaccine type and age when vaccinated; not required after the age of 5 yrs.)
3 Hepatitis B	3 Hepatitis B
1 MMR	2 MMR
1 Varicella (2nd dose required between 4-6 years old)	2 Varicella (2nd dose required for all children entering school for the first time on or after July 1, 2015)
1 - 4 Pneumococcal (Note: Dose # depends on age when vaccinated)	1 - 4 Pneumococcal (Note: # of doses depends on age when vaccinated; not required after the age of 5 yrs. or if born before 7/1/15)
Grades 7	**Grades 8 – 12**
5 DTP/DTaP/DT/Td/Tdap	5 DTP/DTaP/DT/Td/Tdap
4 Polio	4 Polio
3 Hepatitis B	3 Hepatitis B
2 MMR	2 MMR
1 Varicella (if born on or after 4/1/2001)	1 Varicella (if born on or after 4/1/2001)
1 Tdap	1 Tdap
1 Meningococcal	1 - 2 Meningococcal* ***(please see note below)***

*NC now requires two doses of Meningococcal conjugate vaccine (MCV). One dose is required for individuals entering the seventh grade or by 12 years of age, whichever comes first, on or after July 1, 2015. A booster dose is required for individuals entering the 12th grade or by 17 years of age, whichever comes first. Individuals who entered seventh grade before July 1, 2015 are not required to receive the first dose. The booster dose does not apply to individuals who entered the 12th grade before August 1, 2020. If the first dose is administered on or after the 16th birthday, a booster dose is not required. Individuals born before January 1, 2003 shall not be required to receive meningococcal conjugate vaccine.

I have been informed that my child's immunization record and/or health assessment is due on or before their first day of school. I understand that my child will be excluded from school if the required documentation is not received within 30 days of starting school.

Child's/Student's Name: _____ Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____

After your child receives any required immunizations and/or the health assessment, please bring an updated record to school.

Office Instructions: Give copy to parent/guardian. Attach original to orange card and place in student's cumulative folder.

January 2016rev

PUBLIC SCHOOLS OF NORTH CAROLINA
State Board of Education | Department of Public Instruction

NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

This form and the information on this form will be maintained on file in the school attended by the student named herein and is confidential and not a public record.
(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

PARENT to COMPLETE THIS SECTION

Student Name:

(Last) (First) (Middle)

Birthdate (M/D/YYYY): **School Name:**

Home Address: **City:** **State:** **County:**

Parent Information: Name of Parent, Guardian, or person standing in loco parentis:

Telephone(s)

Home:

Work:

Cell Phone:

Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):

HEALTH CARE PROVIDER TO COMPLETE THIS SECTION

Medications prescribed for student:

Student's allergies, type, and response required:

Special diet instructions:

Health-related recommendations to enhance the student's school performance:

Vision screening information:
Passed vision screening: ☐ Yes ☐ No
Concerns related to student's vision:

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Hearing screening information:
Passed hearing screening: ☐ Yes ☐ No
Concerns related to student's hearing:

Recommendations, concerns, or needs related to student's health and required school follow-up:

School follow-up needed: ☐ Yes ☐ No

Medical Provider Comments:

Please attach other applicable school health forms:

Immunization record attached: ☐
School medication authorization form attached: ☐
Diabetes care plan attached: ☐
Asthma action plan attached: ☐
Health care plans for other conditions attached: ☐

Health Care Professional's Certification

I certify that I performed, on the student named above, a health assessment in accordance with G.S. 130A-440(b) that included a medical history and physical examination with screening for vision and hearing, and if appropriate, testing for anemia and tuberculosis. I certify that the information on this form is accurate and complete to the best of my knowledge.

Name: Title:

Signature: _____ Date (m/d/yyyy):

Date of Exam (If Different):

Practice/Clinic Name:			Practice/Clinic Address:	
Practice/Clinic City:	State:	Zip:	Phone:	Fax:

Provider Stamp Here:

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