



Irvine High School

Stu # Student's Name DOB School Grade

Date: April 6, 2011

Our records indicate that your child needs a Tdap vaccine booster to meet the new California School Immunization Law (AB 354) requirements for entry into grades 7 through 12. Health experts have determined that adolescents need a pertussis (whooping cough) booster on or after their 7th birthday. It has also been determined that the required number of doses of any vaccine is necessary for a child to be protected against disease, so we are also indicating any other vaccines that may need to be updated.

To receive a class schedule for Middle or High School, you will need to do one of the following immediately:

- 1. If you or your health care provider have evidence that your child has received the bolded doses (see below), please bring proof of his/her immunizations to the school immediately. Your child's record must contain the date vaccine was given and a doctor's office stamp or signature.
2. If your child has not received the doses highlighted (see below), take this form, along with your child's immunization record, to your physician or another health care provider to obtain the required immunization(s). A parent must be present in order for the child to receive vaccine(s). Once completed, bring your child's updated immunization record or this completed form to the school at once.
3. If any immunizations were not given to your child for medical reasons, please provide the school with a letter of explanation signed by the physician.

Thank you for your prompt attention to this matter. If you have any questions or need assistance in locating a health care provider, please contact the health office at 949-936-7010.

Sheri Kulungian RN., BSN. School Nurse

4321 Walnut Ave. Irvine, CA 92604 School Address

skulungi@iusd.org email

HEALTH CARE PROVIDER REPORT Results may be faxed to the school at 949-936-7029

Immunizations (Needed doses are highlighted):

Form with fields for POLIO, DTP / DTap / TD, Tdap Booster, MMR, HEPATITIS B, HEPATITIS A, VARICELLA, OTHER (Specify) and DTP Booster, Had disease.

Examiner's Name (please print) Signature Date Address Phone Number Fax

Office Stamp