| 2024-2025 California School Immunization Requirements 9th – 12th Admission | |
|---|---|
| **Vaccine** | **Number of Doses Required of Each Immunization** |
| **3 Polio**<br>OPV or IPV | 3 doses meet requirement if 1 dose was given on or after 4th birthday; if not, 4 doses are needed |
| **1 Tdap**<br>Tetanus Toxoid, Reduced Diphtheria Toxoid & Acellular Pertussis<br>**THIS IS A CALIFORNIA STATE REQUIREMENT** | 1 dose of pertussis-containing vaccine is required on or after 7th birthday.<br>Tdap will meet (1) DTaP requirement.<br>*Students will not be allowed to attend school without documentation of a Tdap immunization.* |
| **3 DTaP, DTP**<br>Diphtheria, Tetanus, & Pertussis<br>**Td**<br>Tetanus | 3 doses meet requirement if **Tdap** was given on or after 7th birthday.<br>1-2 doses of Td given on or after 7th birthday count towards the requirement. |
| **3 Hep B**<br>Hepatitis B | 3 doses at any age meets requirement |
| **2 MMR**<br>Measles, Mumps & Rubella | only doses given on or after 1st birthday meet the requirement |
| **2 Varicella**<br>Chickenpox | **"History of chickenpox disease"** does not meet the chickenpox immunization requirement. A **medical exemption** issued using CAIR-ME may be used for a child who had chickenpox disease that was documented by a physician (see below) |
| *There is no requirement for a COVID-19 vaccine for the 2022-2023 school year.* | |

- Since January 1, 2016, **Personal Beliefs Exemptions** for currently-required vaccines are no longer allowed in any school, whether public or private.

- **Medical Exemptions for Required Immunizations -** Starting January 1, 2021, all new medical exemptions for school entry must be issued through the California Immunization Registry – Medical Exemption website CAIR-ME https://cair.cdph.ca.gov/exemptions/home. Parents and physicians can register and create an account in CAIR-ME at any time. Once registered, parents can log in to CAIR-ME to request a medical exemption. Parents take the exemption request number to their child's physician who can log in to CAIR-ME to issue the exemption. Once the exemption is issued, the physician prints the two-page form and provides a copy to the parents to give to their child's school.

- **Existing Medical exemptions issued before 2021** will remain on file at schools and do not need to be uploaded into CAIR-ME.
- **Existing Medical exemptions in CAIR-ME** can be accepted, but parents must update the school information listed in CAIR-ME for the exemption and provide a copy to the school.

- **Medical exemptions issued before January 1, 2020 by physicians who have been disciplined by their medical licensing board** were no longer valid after the beginning of the 2021-2022 school year. To find out if a physician has been disciplined by the Medical Board or Osteopathic Medical Board, please look up an issuing physician's name or medical license number on the list of disciplined physicians.

8/2022

**For more information about immunization requirements and medical exemptions please visit:**
**https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/School/shotsforschool.aspx**

# TRANSFER & INTERNATIONAL STUDENT IMMUNIZATION RECORD '24 -'25

**This record must be completed by a physician from an immunization record provided by a parent or guardian. Dates must include the month, day and year.**

Student Name________________________________________ Grad Yr___________ Sex: M ☐ F ☐ Birthdate (MM/DD/YYYY) ______________________

Name of Parent/Guardian ____________________________________________ Race/Ethnicity: _____________________________________________

Record presented was: _____ Yellow CA Immunization Record _____ CSIR _____ Out-of-State School Record ____ MD translated Record ____Other Immunization Record

| **California Dept of Public Health / ShotsForSchool.org** **REQUIRED IMMUNIZATIONS FOR 9TH-12TH GRADE** | **1st Dose** MM/DD/YYYY | **2nd Dose** MM/DD/YYYY | **3rd Dose** MM/DD/YYYY | **4th Dose** MM/DD/YYYY | **5th Dose** MM/DD/YYYY |
|---|---|---|---|---|---|
| **Polio** OPV or IPV **3 doses** meet requirement if one dose was given on or after the 4th birthday. If not, 4 doses are needed | ___/___/_____ | ___/___/_____ | ___/___/_____ Age _______ years | ___/___/_____ | |
| **DTP/DTaP** Diphtheria, Tetanus, & Pertussis **3 doses** meet requirement if **Tdap** was given on or after 7th birthday ***Td** Tetanus 1-2 doses given on or after 7th birthday count towards the requirement | ___/___/_____ | ___/___/_____ | ___/___/_____ Age _______ years | ___/___/_____ Age _______ years | ___/___/_____ |
| **Tdap/Boostrix/Adacel** Tetanus Toxoid, Reduced Diphtheria Toxoid & Acellular Pertussis **1 dose on or after 7th birthday**. Tdap will meet DTaP requirement | ___/___/_____ Age _______ years | **THIS IS A CALIFORNIA STATE REQUIREMENT** | | | |
| **HEP B** (Hepatitis B) **3 doses** | ___/___/_____ | ___/___/_____ | ___/___/_____ | | |
| **MMR** combined immunization for Measles, Mumps & Rubella **2 doses** (on or after 1st birthday) | ___/___/_____ Age _______ years | ___/___/_____ Age _______ years | | | |
| ***OR** doses given separately for Measles, Mumps & Rubella list below:* **Measles** Rubella – 10 day Measles **2 doses** (on or after 1st birthday) | ___/___/_____ | ___/___/_____ | | | |
| **Mumps 2 doses** (on or after 1st birthday) | ___/___/_____ | ___/___/_____ | | | |
| **Rubella** German Measles – 3 day Measles **1 dose** (on or after 1st birthday) | ___/___/_____ | ___/___/_____ | | | |
| **Varicella** (Chickenpox) **2 doses** | ___/___/_____ | ___/___/_____ | | | |

| PHYSICIAN'S NAME (please type or print): | PHYSICIAN'S SIGNATURE: | DATE: | PHYSICIAN'S STAMP/SEAL (REQUIRED): |
|---|---|---|---|
| ADDRESS: | PHONE: | | |

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## OTHER IMMUNIZATIONS (NOT REQUIRED)

## TRANSFER & INTERNATIONAL STUDENT IMMUNIZATION RECORD '24 – '25

**This record must be completed by a physician from an immunization record provided by a parent or guardian. Dates must include the month, day and year.**

Student Name_______________________________________________ Sex: M F Birthdate (MM/DD/YYYY) _______________________________

| VACCINE | 1st Dose MM/DD/YYYY | 2nd Dose MM/DD/YYYY | 3rd Dose MM/DD/YYYY | 4th Dose MM/DD/YYYY | 5th Dose MM/DD/YYYY |
|---|---|---|---|---|---|
| **Hepatitis A** | ___/___/_____ | ___/___/_____ | | | |
| **Hib** (Haemophilus influenza type b) | ___/___/_____ | ___/___/_____ | ___/___/_____ | ___/___/_____ | |
| **Meningococcal / Meningitis**<br>1 dose recommended for college admission | ___/___/_____ | ___/___/_____ | ___/___/_____ | ___/___/_____ | ___/___/_____ |
| **Pneumococcal** | ___/___/_____ | ___/___/_____ | ___/___/_____ | ___/___/_____ | ___/___/_____ |
| **HPV (Human Papillomavirus)** | ___/___/_____ | ___/___/_____ | ___/___/_____ | ___/___/_____ | ___/___/_____ |
| **Influenza** | ___/___/_____ | ___/___/_____ | ___/___/_____ | ___/___/_____ | ___/___/_____ |
| **COVID-19 Vaccine Type:** ___________________ | ___/___/_____ | ___/___/_____ | | | |
| **COVID-19 Booster Type**:___________________ | ___/___/_____ | ___/___/_____ | ___/___/_____ | ___/___/_____ | ___/___/_____ |
| **BCG** Tuberculosis vaccine | ___/___/_____ | ___/___/_____ | | | |
| **PPD-Mantoux** Tuberculosis Testing (most recent) | ___/___/_______ Positive ☐ Negative ☐ | CXR ___/___/___ | Normal ☐ Abnormal ☐ | | |
| Other | ___/___/_____ | ___/___/_____ | ___/___/_____ | ___/___/_____ | ___/___/_____ |

| PHYSICIAN'S NAME (please type or print): | PHYSICIAN'S SIGNATURE: | DATE: | PHYSICIAN'S STAMP/SEAL (REQUIRED): |
|---|---|---|---|
| ADDRESS: | PHONE: | | |