**NOTICE of Exclusion**
**Immunization Record Needed**
**for School/Child Care Attendance**

_Note to Health Care Provider: Colorado Statute 6 CCR 1009-2 mandates the establishment of school required vaccines through the authority of the Colorado Board of Health as a requirement for student attendance at Colorado Schools. The “required” schedule closely follows the ACIP/AAP recommended schedule. Please contact the Colorado Immunization Section at 303-692-2650 if you have questions about the school required vaccine requirements. Thank you._

To the parent/guardian of: ____________________________

The child listed above does not have an up-to-date Certificate of Immunization on file and cannot attend this school/childcare until a completed immunization record is received (according to Colorado law). The exclusion date will be enforced on _____________. Please contact your health care provider or local health department at ______________ to obtain the required immunization(s).

The following shots are needed:
- ____ DTaP (Diphtheria/Tetanus/Pertussis)
- ____ Tdap (Tetanus/Diphtheria/Pertussis)
- ____ Td (Tetanus/Diphtheria)
- ____ Polio
- ____ MMR (Measles/Mumps/Rubella)
- ____ Hib (Haemophilus Influenzae type b)
- ____ PCV13 (Pneumococcal Conjugate)
- ____ Hepatitis B
- ____ Varicella (Chickenpox)

*All reporting of Chickenpox disease is to be documented by a healthcare provider (physician or RN)*

Please note: If an immunization is against your religious beliefs, you must sign a religious exemption. If your child cannot receive an immunization for medical reasons, a physician must sign a medical exemption. If you have personal beliefs opposed to an immunization, you must sign a personal exemption. Exemption forms can be found on the reverse side of the Colorado Department of Public Health and Environment Certificate of Immunization.

**Signed:** ___________________________________________ **Date:** __________________________

**School/Childcare:** ___________________________________ **Phone:** __________________________

**Fax:** __________________

**Method of Notification:** ___ Phone   ___ Mail   ___ In Person

☐ If this box is marked, more than one dose of an immunization noted above is needed, and the plan below must be completed by a healthcare provider, signed by you, and returned to us by the due date above. As shots are received, submit the record to us. This plan will be in process until the official Certificate of Immunization is completed.

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>HEALTHCARE PROVIDER</th>
<th>DUE TO BE RECEIVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td>Name</td>
<td>Phone Number</td>
</tr>
<tr>
<td>Tdap</td>
<td>Name</td>
<td>Phone Number</td>
</tr>
<tr>
<td>Td</td>
<td>Name</td>
<td>Phone Number</td>
</tr>
<tr>
<td>Polio</td>
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<tr>
<td>MMR</td>
<td>Name</td>
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<tr>
<td>Hib</td>
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<td>Phone Number</td>
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<tr>
<td>PCV13</td>
<td>Name</td>
<td>Phone Number</td>
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<tr>
<td>Hepatitis B</td>
<td>Name</td>
<td>Phone Number</td>
</tr>
<tr>
<td>Varicella</td>
<td>Name</td>
<td>Phone Number</td>
</tr>
</tbody>
</table>

Schedule must follow medically recommended intervals consistent with ACIP, AAP, or the vaccine manufacturer's package insert.

I agree to the above plan for receiving the required shots, submitting the records, and completing the Certificate of Immunization.

Signed: ___________________________________________ **Date:** __________________________