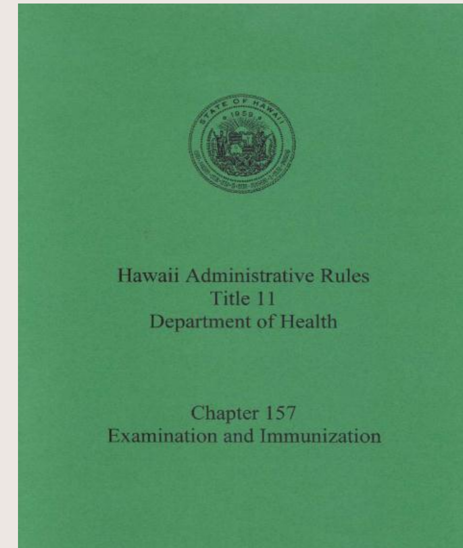
Immunization & Examination Requirements for School Entry

Immunization & Examination Requirements for School Entry

- Hawaii Revised Statutes (State Laws)
- Hawaii Administrative Rules (HAR) Chapter 11-157



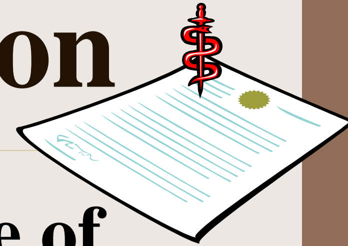
Health Requirements

- Physical Examination (PE)
- Tuberculosis (TB) Examination
- Immunizations

Physical Examination

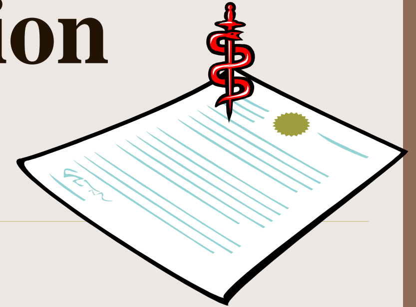
- Each student must present a record of PE before first attending school in Hawaii
- Must be performed within 12 months before first school attendance
- Must be performed and signed by a U.S. licensed physician, APRN, or PA
- A valid PE may be used for transfer into all other schools in Hawaii

Tuberculosis Examination



- Each student must provide a certificate of TB examination before first attending school in Hawaii
- Must be performed within 12 months before first attending school in Hawaii
- Must be issued by Hawaii DOH, or a U.S. licensed physician, APRN, or PA
- A valid certificate of TB examination may be used for transfer into all other schools in Hawaii

Tuberculosis Examination (continue)



- **Must be a Mantoux tuberculin skin test (PPD). Tine test is not acceptable**
- **A certificate of TB must include:**
  - **date administered & read**
  - **results in millimeters**
  - **Signature or stamp of MD, DO, APRN, PA, or clinic**

Tuberculosis Examination (continue)

- **TB test Results:**
  - **<10 mm: acceptable for school entry**
  - **≥10 mm: must also have a chest x-ray (CXR). Written documentation of a negative CXR must be provided prior to first attendance at school**

Tuberculosis Examination (continue)

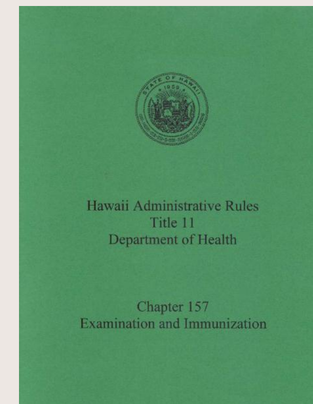
- **Students with a documented of past positive PPD test, may have a CXR performed and certificate issued without a repeat skin test**

Tuberculosis Examination (continue)

- **Children who first attend school before age 12 months:**
  - **must turn in a TB certificate before they reach 14 months of age, or be excluded from school until the certificate is obtained**

Required Immunizations - Preschool

- For children less than 19 months of age, required immunizations are based on the child’s age
- HAR Chapter 11-157, Exhibit B (page 2) Table 1

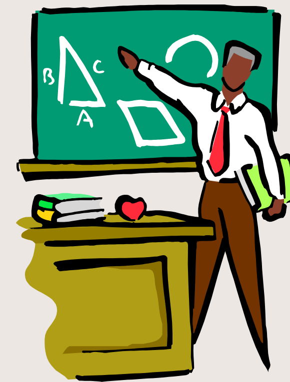


Required Immunizations - Preschool (continue)

- **For children 19 months of age & older:**
  - **4 DTaP**
  - **3 Polio**
  - **1 MMR**
  - **1 Hib** **(at least one dose of *Hib* on or after 12 months of age)**
  - **3 Hep B**
  - **1 varicella**

Required Immunizations Grade Kindergarten - 12

- 5 DTaP
- 4 Polio
- 2 MMR
- 3 Hep B*
- 1 or 2 varicella**



*3 doses of hepatitis B vaccine are required for school attendance for all students born after December 31, 1992 and for 7th grade attendance

**2 doses of varicella vaccine are required if the first dose is given on or after the 13th birthday

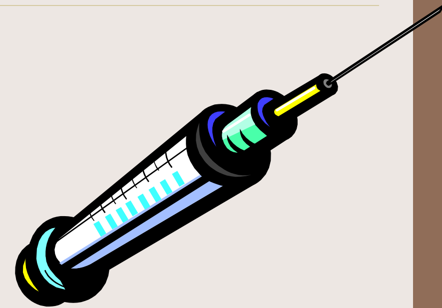
Required Immunizations - 7th grade attendance*

- **2 MMR**
- **3 Hep B**
- **1 or 2 varicella****

*In addition to meeting the K-12 immunization requirements

**2 doses are required if the first dose is administered on or after age 13 years

Immunization Requirements



- Must have complete dates (month/day/year)
- Must meet minimum ages & intervals between doses
- Must be signed or stamped by a U.S. licensed physician, APRN, PA, or clinic

Immunity by serologic testing

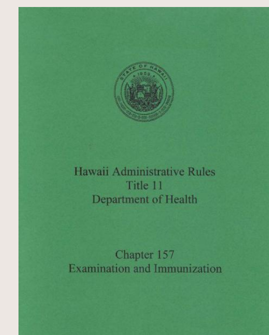
- **Laboratory evidence of immunity may be substituted for a record of immunization**
- **Requires a laboratory report, signed by a U.S. licensed physician, APRN, or PA certifying that student is immune to the specified disease**

Clinical history of varicella infection

- A documented history of varicella (chickenpox), <u>signed</u> by a U.S. licensed physician, APRN, or PA may be substituted for the varicella vaccine requirement

Minimum intervals between vaccine doses

- **HAR, Chapter 11-157, Exhibit B -Table 5**
- **There is No maximum interval between doses**
- **An immunization given before the minimum age or interval between doses will NOT be acceptable for school entry**



4-Day “Grace Period”

- **A grace period of 4 days applies to each minimum age & interval**

Exemptions

- **Apply to Immunizations**
- **Two types: Medical or Religious**
- **There are No exemptions to the TB clearance requirement**
- **Philosophical exemptions are Not allowed by the State.**

Medical Exemption

- **A medical exemption may be granted by a U.S. licensed physician**
- **A physician must state in writing that giving a specific vaccine would endanger the student's life or health and specify the medical reason**

Medical Exemption (continue)

- **Must state the length of time during which the vaccine would endanger the student's health or life**
- **Must be on the stationery or printed forms of the physician**

Religious Exemption

- **Parent/guardian must sign a statement certifying that the person's religious beliefs prohibit the practice of immunization (DOH EPI 7 Form)**
- **A religious exemption based on an objection to a *specific vaccine* will not be granted**

Provisional Attendance

- **A student who does not complete:**
  - **all required immunizations**
  - **report of a PE**

  may attend school **provisionally** upon submitting written proof (appointment card) from a health care provider that the student is in the process of completing the missing requirements

- **There is <u>NO</u> provisional attendance for students lacking a TB clearance**

Provisional Attendance (continue)

Students attending school on provisional attendance status have 3 months from the date of provisional attendance to complete the missing health requirements

(EPI 10B)

Provisional Attendance
(continue)

- **Students who do not complete the missing immunizations or PE within 3 months will be excluded from school**
- **School should send parent the "Notice of Exclusion" (EPI 10D), stating the student will be excluded 30 calendar days from the date of the notice**

Provisional Attendance (continue)

- **Beginning 30 days after the date of the "Notice of Exclusion," the student shall be excluded from school**
- **Student may attend school after bringing documentation showing completing of the missing health requirements**

- Screening Records
- Case Study

Resource: How to complete the Form 14:

How to Complete the Form 14

Complete date is not necessary. Year alone or age is acceptable.

SAMPLE

Department of Education
STUDENT'S HEALTH RECORD

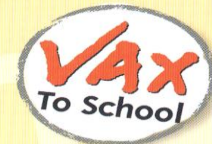
Signature or stamp not required IF appropriate box is checked above (see color coded boxes) and MD, DO, APRN or PA has signed under "Provider Signature."

MD, DO, APRN or PA signature and stamp goes here.

Please document the date and type of each immunization.

Only use **current** Form 14, dated Rev. 2002.

Additional cardstock copies of the Form 14 may be ordered from the Department of Education's District Offices.
Honolulu: 733-4950 • Leeward: 692-8000 • Central: 627-7478 • Windward: 233-5700
Hawaii: 974-6600 • Kauai: 274-3502 • Maui: 984-8000



Screening Health Record: Case Sample (Form 14)

Department of Education
STUDENT'S HEALTH RECORD

Student Address Label

Name: Immunize (Last) Tom (First) (Middle Initial)

Female ☐ Male ☑

Preschool: Entry Date / /
Elementary: Entry Date 9/1/03
Intermediate/Middle: Entry Date / /
High: Entry Date / /

Birthdate: 07 (Month) 01 (Day) 1998 (Year)

Parent's Name: (Mother/Guardian) (Father/Guardian)

Keiki School
1234 Hawaii Lane
Honolulu, HI 12345

will enter kindergarten: 9/1/03

Please complete the following sections (CHECK IF YES)

Kindergarten enrollment: 51 Grades 1-8 enrollment: 1215 7th Gr enrollment: 95

MEDICAL STATUS

Allergy (type) ☐	Cancer/Leukemia ☐	Hearing Problems ☐	Rheumatic Heart ☐
Asthma ☐	Chronic Cough/Wheezing ☐	Heart Disease ☐	Sickle Cell Anemia ☐
Vision Problems ☐	Diabetes ☐	Hemophilia ☐	Seizures ☐

PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE

Date	Grade	Height	Weight	Blood Pressure	Vision R.	Vision L.	Hearing R.	Hearing L.	Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Significant Findings and Recommendations	Varicella Immunity Secondary to Disease (DATE)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
2/10/03		38"	40	110/60	20/20	20/20	N	N	N												N		/ /	✓	✓	[signature] MD	
/ /																							/ /				
/ /																							/ /				
/ /																							/ /				

TUBERCULOSIS EXAMINATION
MANTOUX TEST (INTRADERMAL)

Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic (Signature or Stamp if Different from Above)	Y* N
2/10/03	2/12/03	0mm		☐ ☐
/ /	/ /			☐ ☐
/ /	/ /			☐ ☐

CHEST X-RAY

Date	Results	Location	Y* N
			☐ ☐
			☐ ☐

DENTAL EXAMINATION

Dental Check-Up	/ /	☐ ☐

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)

DTaP, DTP, DT, or Td Type	Date Given	Polio (IPV or OPV) Type	Date Given	HIB Type	Date Given	Hepatitis B Date Given	Varicella Date Given	MMR Date Given
DTaP	9/1/98	IPV	9/1/98	Act HIB	9/1/98	7/2/98	10/2/00	5/10/99
DTaP	11/2/98	IPV	11/2/98	Act HIB	11/2/98	9/1/98	/ /	8/1/02
DTaP	1/25/99	IPV	1/25/99	Act HIB	7/30/00	1/25/99	/ /	/ /
DTaP	8/1/02		/ /		/ /	/ /	/ /	/ /

OTHER

	Date Given	Type	Date Given	Date Given	Date Given	
	/ /					Measles / /
	/ /		/ /	/ /	/ /	Mumps / /
	/ /		/ /	/ /	/ /	Rubella / /

Y* N: DTaP ☐ ☐; Polio ☐ ☐; HIB ☐ ☐; HEP ☐ ☐; MMR ☐ ☐; Varicella ☐ ☐

Physician, APRN, PA or Clinic ______
(Signature or stamp if different from above)

*OFFICE USE ONLY (Rev. 2002)

Case Sample:

Student Name & Birthdate

Department of Education
STUDENT'S HEALTH RECORD

Name Immunize (Last) Tom (First) (Middle Initial)

Female ❑ Male ☑

Birthdate 0 7 | 0 1 | 1 9 9 8
Month Day Year

Case Sample: PE – date performed (within 12 months of school entry date)

Department of Education
STUDENT'S HEALTH RECORD

Name Immunize (Last) Tom (First) (Middle Initial)

Birthdate 07 01 1998 (Month Day Year)

Female ☐ Male ☑

Preschool: Entry Date / /
Elementary: Entry Date 9 / 1 / 03
Intermediate/Middle: Entry Date / /
High: Entry Date / /
will enter kindergarten: 9/1/03
Grades 1-8 enrollment: 121

Student Address Label

Keiki School
1234 Hawaii Lane
Honolulu, HI 12345

Parent's Name (Mother/Guardian) (Father/Guardian)

Please complete the following sections (CHECK IF YES)

Allergy (type) ☐
Asthma ☐
Vision Problems ☐
Cancer/Leukemia
Chronic Cough/Wh
Diabetes

PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-AB

Date	Grade	Height	Weight	Blood Pressure	Vision R.	Vision L.	Hearing R.	Hearing L.	Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition
2/10/03		38"	40	110/60	20/20	20/20	N	N	N												N
/ /																					

DTaP ☐ ☐
Polio ☐ ☐
HIB ☐ ☐
HEP ☐ ☐
MMR ☐ ☐
Varicella ☐ ☐

Case Sample: PE – Valid provider signature (with physician credentials)

Department of Education
STUDENT'S HEALTH RECORD

Name: Immunize (Last) Tom (First) (Middle Initial)
Birthdate: 07 01 1998 (Month Day Year)
Female ☐ Male ☑
Preschool: Entry Date / /
Elementary: Entry Date 9/1/03
Intermediate/Middle: Entry Date / /
High: Entry Date / /
Student Address Label

Parent's Name (Mother/Guardian) (Father/Guardian)
will enter kindergarten: 9/1/03
Keiki School
1234 Hawaii Lane
Honolulu, HI 12345
Please complete the following sections (CHECK IF YES)
Kindergarten enrollment: 51 Grades 1-8 enrollment: 1215 7th Gr enrollment: 95

MEDICAL STATUS

Allergy (type) ☐	Cancer/Leukemia ☐	Hearing Problems ☐	Rheumatic Heart ☐
Asthma ☐	Chronic Cough/Wheezing ☐	Heart Disease ☐	Sickle Cell Anemia ☐
Vision Problems ☐	Diabetes ☐	Hemophilia ☐	Seizures ☐

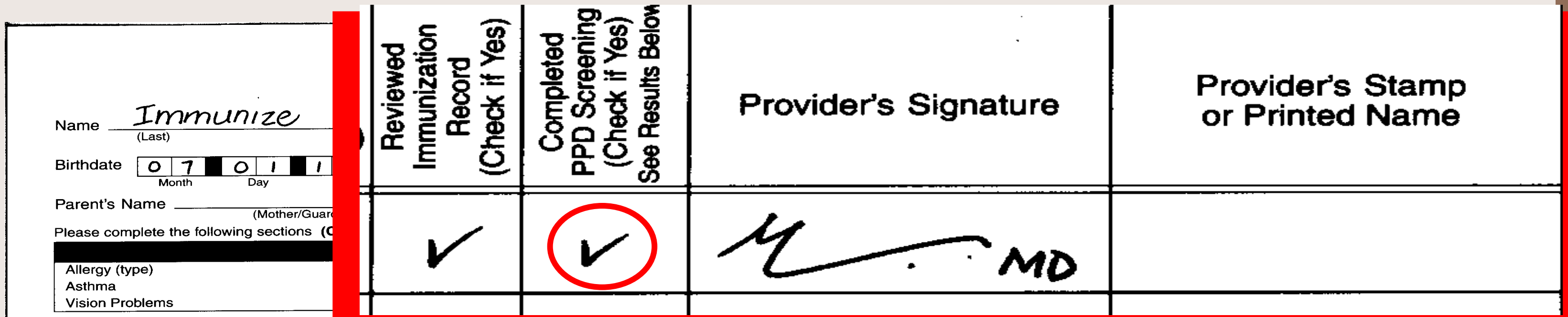
PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE

Date	Grade	Height	Weight	Blood Pressure	Vision R.	Vision L.	Hearing R.	Hearing L.	Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Significant Findings and Recommendations	Varicella Immunity Secondary to Disease (DATE)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
2/10/03		38"	40	110/60	20/20	20/20	N	N	N												N		/ /	✓	✓	[signature] MD	
/ /																											

Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
✓	✓	[signature] MD	

Date Given: 2/10/ ... Date Given: 5/10/99, 8/1/02
Y N: DTaP ☐ ☐, Polio ☐ ☐, HIB ☐ ☐, HEP ☐ ☐, MMR ☐ ☐, Varicella ☐ ☐
Measles, Mumps, Rubella
Date
Dental
*OFFIC

Case Sample: Valid TB certification (documented by physician)



Name Immunize (Last)

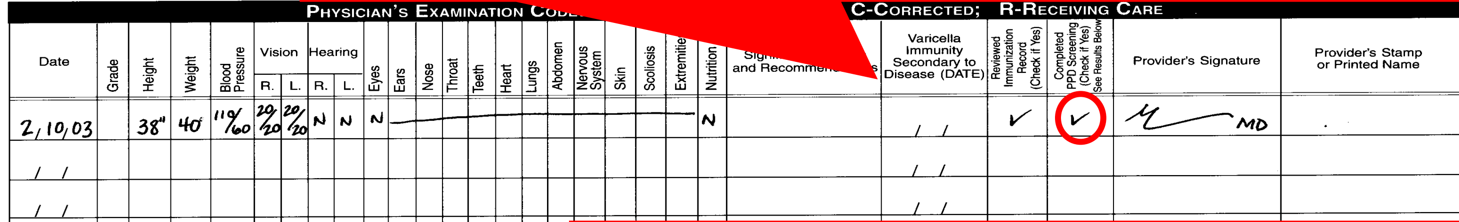
Birthdate 0 7 | 0 1 | 1 — Month, Day

Parent's Name (Mother/Guar...)

Please complete the following sections (C...

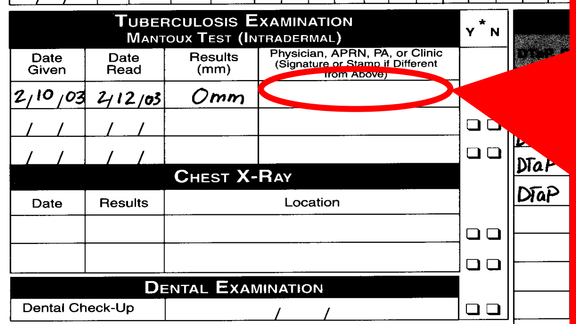
Allergy (type)
Asthma
Vision Problems

Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
✓	✓	MD	



Physician's Examination Code... C-Corrected; R-Receiving Care

Date	Grade	Height	Weight	Blood Pressure	Vision R.	Vision L.	Hearing R.	Hearing L.	Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Signi... and Recommen...	Varicella Immunity Secondary to Disease (DATE)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
2/10/03		38"	40	110/60	20/20	20/20	N	N	N												N		/ /	✓	✓	MD	
/ /																							/ /				
/ /																							/ /				
/ /																											



Tuberculosis Examination — Mantoux Test (Intradermal)

Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic (Signature or Stamp if Different from Above)
2/10/03	2/12/03	0mm	
/ /	/ /		
/ /	/ /		

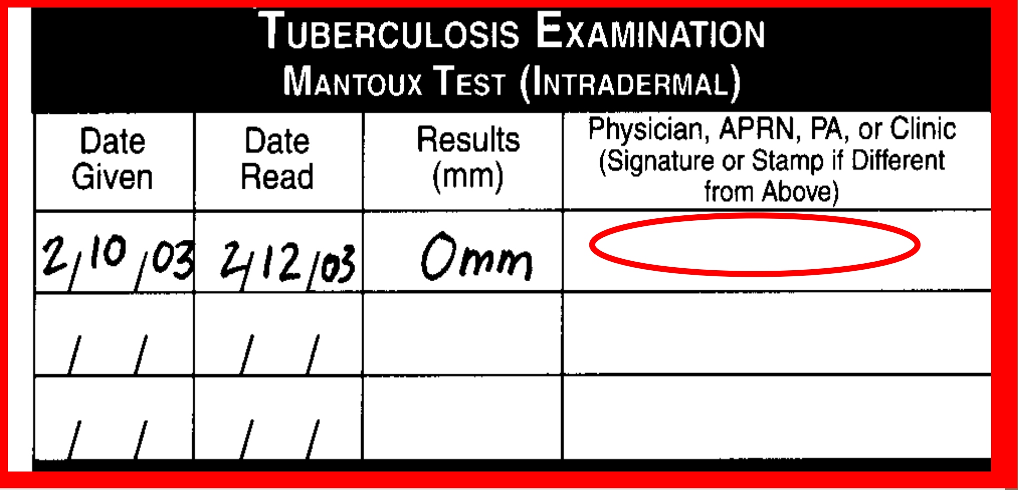
Chest X-Ray

Date	Results	Location

Dental Examination

Dental Check-Up / /

*OFFICE USE ONLY (Rev. 2002)



Tuberculosis Examination — Mantoux Test (Intradermal)

Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic (Signature or Stamp if Different from Above)
2/10/03	2/12/03	0mm	
/ /	/ /		
/ /	/ /		

Case Sample:
Screening Record – Immunizations

Department of Education
STUDENT'S HEALTH RECORD

Student Address Label

Name: Immunize (Last) Tom (First) (Middle Initial)

Birth date: 07 (Month) 01 (Day) 1998 (Year)

Female ☐ Male ☑

Preschool: Entry Date / /
Elementary: Entry Date 9/1/03
Intermediate/Middle: Entry Date / /
High: Entry Date / /

Parent's Name (Mother/Guardian) (Father/Guardian)

will enter kindergarten: 9/1/03

Keiki School
1234 Hawaii Lane
Honolulu, HI 12345

Please complete the following sections (CHECK IF YES)

Kindergarten enrollment: 51 Grades 1-8 enrollment: 1215 7th Gr enrollment: 95

MEDICAL STATUS

Allergy (type) ☐ Cancer/Leukemia ☐ Hearing Problems ☐ Rheumatic Heart ☐

Asthma
Vision

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)

DTaP, DTP, DT, or Td		Polio (IPV or OPV)		HIB *Haemophilus influenzae* type B		Hepatitis B	Varicella	MMR
Type	Date Given	Type	Date Given	Type	Date Given	Date Given	Date Given	Date Given
DTaP	9/1/98	IPV	9/1/98	Act HIB	9/1/98	7/2/98	10/2/00	5/10/99
DTaP	11/2/98	IPV	11/2/98	Act HIB	11/2/98	9/1/98	/ /	8/1/02
DTaP	1/25/99	IPV	1/25/99	Act HIB	7/30/00	1/25/99	/ /	/ /
DTaP	8/1/02		/ /		/ /	/ /	/ /	/ /
	/ /							Measles
								/ /

OTHER				Mumps
Type	Date Given	Date Given	Date Given	/ /
	/ /	/ /	/ /	Rubella
	/ /	/ /	/ /	/ /

Physician, APRN, PA or Clinic
(Signature or stamp if different from above)

Date
2/10/
Date Given
2/10/0
Date
Dental
*OFFICE

DTaP ☐ Polio ☐ HIB ☐ HEP ☐ MMR ☐ Varicella ☐

DTaP or DTP Vaccine

Minimum ages and intervals between doses:

Name Immunize Tom
(Last) (First) (Middle Initial)
Female ☐
Male ☑
Birthdate 0 7 0 1 1 9 9 8
Month Day Year

DTaP, DTP, DT, or Td	
Type	Date Given
DTaP	9 / 1 / 98
DTaP	11 / 2 / 98
DTaP	1 / 25 / 99
DTaP	8 / 1 / 02
	/ /

- **1st dose:** on or after 6 weeks of age
- **2nd dose:** at least 4 weeks after 1st dose
- **3rd dose:** at least 4 weeks after 2nd dose
- **4th dose:** at least 6 months after 3rd dose and not before12 months of age
- **5th dose:** on or after 4 years of age

Exceptions for DTaP

DTaP, DTP, DT, or Td	
Type	Date Given
DTaP	9 / 1 / 98
DTaP	11 / 2 / 98
DTaP	1 / 25 / 99
DTaP	8 / 1 / 02
	/ /

Students who received their 4th dose of DTaP on or after their 4th birthday are not required to receive a 5th dose

Name Immunize Tom
(Last) (First) (Middle Initial)
Female ☐
Male ☑
Birthdate 0 7 0 1 1 9 9 8
Month Day Year

Polio Vaccine

Minimum ages and intervals between doses:

IMMUNIZATIONS

Polio (IPV or OPV)	
Type	Date Given
IPV	9/1/98
IPV	11/2/98
IPV	1/25/99
	/ /

Name: Immunize (Last) Tom (First) (Middle Initial)

Female ☐ Male ☑

Birthdate: 07 (Month) 01 (Day) 1998 (Year)

- **1st dose:** on or after age 6 weeks
- **2nd dose:** at least 4 weeks after 1st dose
- **3rd dose:** at least 4 weeks after 2nd dose
- **4th dose:** at least 4 weeks after 3rd dose

Exceptions for Polio

For students who receive only OPV or IPV:

if the 3rd dose was given on or after the 4th birthday, the 4th dose is not required

For students that receive any combination of the OPV or IPV:

4 doses of Polio vaccine are required regardless of age when the series was initiated or completed

Hepatitis B Vaccine

Minimum ages and intervals between doses:

(MONTH/DAY/YEAR)

Hepatitis B
Date Given
7 / 2 / 98
9 / 1 / 98
1 / 25 / 99
/ /

Name Immunize (Last) Tom (First) (Middle Initial)

Female ☐ Male ☑

Birthdate 0 7 | 0 1 | 1 9 9 8 (Month / Day / Year)

- **1st dose:** may be given at birth
- **2nd dose:** at least 4 weeks after 1st dose
- **3rd dose:** at least 8 weeks after 2nd dose, and 4 months after 1st dose but not before age 6 months

Varicella Vaccine

Minimum ages and intervals between doses:

Varicella

Date Given

10 / 2 / 00

- **1st dose**: on or after 12 months of age
- **2nd dose**: at least 4 weeks after 1st dose (only required if 1st dose is given on or after age 13 years

Name Immunize (Last) Tom (First) (Middle Initial)

Female ❑ Male ☑

Birthdate 0 7 (Month) 0 1 (Day) 1 9 9 8 (Year)

MMR – Measles, Mumps, Rubella

Minimum ages and intervals between doses:

MMR
Date Given
5 / 10 / 99
8 / 1 / 02
/ /
/ /

Name Immunize (Last) Tom (First) (Middle Initial)

Female ☐ Male ☑

Birthdate 0 7 0 1 1 9 9 8 (Month Day Year)

- **1st dose**: on or after 12 months of age
- **2nd dose**: at least 4 weeks after the 1st dose

MMR (Case Sample - Tom Immunize)

MMR

Date Given

5/10/99

8/1/02

/ /

/ /

- **2 doses of MMR given:**
  - ✓1st dose invalid (given before 12 months of age)
  - ✓2nd dose becomes first valid dose
  - ✓ Tom needs one more dose of MMR

Name Immunize (Last) Tom (First) (Middle Initial)

Female ☐ Male ☑

Birthdate 0 7 (Month) 0 1 (Day) 1 9 9 8 (Year)

Case Sample: Screening Results
Tom Immunize - Form 14

Department of Education
STUDENT'S HEALTH RECORD

Name: Immunize (Last) Tom (First) (Middle Initial)

Birthdate: 07 / 01 / 1998 (Month / Day / Year)

Female ☐ Male ☑

Preschool:	Entry Date / /
Elementary:	Entry Date 9/1/03
Intermediate/Middle:	Entry Date / /
High:	Entry Date / /

Student Address Label

Keiki School
1234 Hawaii Lane

Parent's Name

will enter kindergarten: 9/1/03

- Tom is missing polio dose number 4
- He is also missing MMR dose number 2 because the 1st dose was given before the minimum age of 12 months.

TUBERCULOSIS EXAMINATION
MANTOUX TEST (INTRADERMAL)

Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic (Signature or Stamp if Different from Above)	Y* N
2/10/03	2/12/03	0mm		☐ ☐
/ /	/ /			☐ ☐
/ /	/ /			☐ ☐

CHEST X-RAY

Date	Results	Location	
			☐ ☐
			☐ ☐

DENTAL EXAMINATION

Dental Check-Up	/ /	☐ ☐

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)

DTaP, DTP, DT, or Td Type	Date Given	Polio (IPV or OPV) Type	Date Given	HIB Haemophilus influenzae type B Type	Date Given	Hepatitis B Date Given	Varicella Date Given	MMR Date Given
DTaP	9/1/98	IPV	9/1/98	Act HIB	9/1/98	7/2/98	10/2/00	5/10/99
DTaP	11/2/98	IPV	11/2/98	Act HIB	11/2/98	9/1/98	/ /	8/1/02
DTaP	1/25/99	IPV	1/25/99	Act HIB	7/30/00	1/25/99	/ /	/ /
DTaP	8/1/02		/ /		/ /	/ /	/ /	/ /

OTHER

Type	Date Given	Date Given	Date Given
	/ /	/ /	/ /
	/ /	/ /	/ /

Measles / / — Mumps / / — Rubella / /

Y* N: DTaP ☐ ☐ — Polio ☐ ☐ — HIB ☐ ☐ — HEP ☐ ☐ — MMR ☐ ☐ — Varicella ☐ ☐

Physician, APRN, PA or Clinic
(Signature or stamp if different from above)

*OFFICE USE ONLY (Rev. 2002)

EPI 12B Form - Section #1
Case Sample: Tom Immunize

Hawai'i Department of Health

HAWAII STATE DEPARTMENT OF HEALTH

IMMUNIZATION ASSESSMENT REPORT FOR PUBLIC and PRIVATE SCHOOLS

Use this form to list all *incompletely* immunized students, grades K-12. Include students with exemptions to immunizations.

Report #1 due **October 10**
Report #2 due **January 10**

#1. School: Keiki School

Mailing Address: 1234 Hawaii Lane
City, Zip: Honolulu, HI 12345

Location Address: 1234 Hawaii Lane
City, Zip: Honolulu, HI 12345

Prepared By: Your name
Title: Your Title
Phone: Your phone
Date: Todays date
Fax: Your Fax

Enrollment
Kindergarten: 51
Other grades (1 to 8): 1215
Total enrollment: 1266
7th Grade enrollment only: 45

Does this school have a pre-k program? Yes ☐ No ☑
If YES, please complete the Immunization Assessment Report for CHILD CARE CENTERS, PRESCHOOLS AND HEAD START Programs (EPI12A).
Do not list pre-k students on this form.

EPI 12 B Form - Section #2 & #3

Case Sample: Tom Immunize

HAWAII STATE DEPARTMENT OF HEALTH

Hawai'i Department of Health

Report #1 due October 10
Report #2 due January 10

IMMUNIZATION ASSESSMENT REPORT FOR PUBLIC and PRIVATE SCHOOLS

Use this form to list all *incompletely* immunized students, grades K-12. Include students with exemptions to immunizations.

#2. All enrollees meet the immunization requirements: Yes ☐ No ☐ If No, please complete Section #3

#3. Name of Student List only students who are missing required immunizations and students who have an exemption to ANY immunization.	BIRTH DATE (mm/dd/yy)	GRADE	ENTRY DATE (mm/dd/yy)	NO Immunization Record	EXEMPT		Mark an (X) in column of missing vaccine dose(s)																PE	TB	Notes
					Religious	Medical	DTaP / DTP / DT / Td					POLIO				HEPATITIS B			MMR		Varicella				
							1	2	3	4	5	1	2	3	4	1	2	3	1	2	1	2			
Tom Immunize	7/1/98	K	9/1/03												X					X					
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EPI 12 Form -Exemptions: Medical and Religious
Case Sample: Tom Immunize

HAWAII STATE DEPARTMENT OF HEALTH

Hawai'i Department of Health

Report #1 due October 10
Report #2 due January 10

IMMUNIZATION ASSESSMENT REPORT FOR PUBLIC and PRIVATE SCHOOLS

Use this form to list all *incompletely* immunized students, grades K-12. Include students with exemptions to immunizations.

#3. Name of Student — List only students who are missing required immunizations and students who have an exemption to ANY immunization.	BIRTH DATE (mm/dd/yy)	GRADE	ENTRY DATE (mm/dd/yy)	NO Immunization Record	EXEMPT Religious	EXEMPT Medical	DTaP / DTP / DT / Td 1	2	3	4	5	POLIO 1	2	3	4	HEPATITIS B 1	2	3	MMR 1	2	Varicella 1	2	PE	TB	Notes
Tom Immunize	7/1/98	K	9/1/03												X					X					
	/ /		/ /																						
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Mark an (X) in column of missing vaccine dose(s)

A Sample of a Final Report - EPI 12B

(Grades K-12)

HAWAII STATE DEPARTMENT OF HEALTH

Hawai'i Department of Health

Report #1 due **October 10**
Report #2 due **January 10**

IMMUNIZATION ASSESSMENT REPORT FOR PUBLIC and PRIVATE SCHOOLS

Use this form to list all *incompletely* immunized students, grades K-12. Include students with exemptions to immunizations.

#1. School: Keiki School		Prepared By: Your Name		Enrollment		Does this school have a pre-k program? Yes ☐ No ☒
Mailing Address: 1234 Hawaii Lane	City, Zip: Honolulu, HI 99999	Title: Your Title	Phone: Your Phone	Kindergarten:	51	If YES, please complete the Immunization Assessment
				Other grades (1 to 8):	1215	Report for CHILD CARE CENTERS, PRESCHOOLS
Location Address: 1234 Hawaii Lane	City, Zip: Honolulu, HI 99999	Date: Submit Date	Fax: Your Fax	Total enrollment:	1266	AND HEAD START Programs (EPI12A).
				7th Grade enrollment only:	95	**Do not list pre-k students on this form.**

#2. All enrollees meet the immunization requirements: Yes ☐ No ☐ **If No, please complete Section #3.**

#3. Name of Student List only students who are missing required immunizations and students who have an exemption to ANY immunization	BIRTH DATE (mm/dd/yy)	GRADE	ENTRY DATE (mm/dd/yy)	NO Immunization Record	EXEMPT Religious	EXEMPT Medical	DTaP / DTP / DT / Td 1	2	3	4	5	POLIO 1	2	3	4	HEPATITIS B 1	2	3	MMR 1	2	Varicella 1	2	PE	TB	Notes
Tom Immunize	7/01/98	K	9/1/03												X					X					
	/ /		/ /																						
Peter Pan	7/12/98	K	7/26/03					X	X	X							X	X							
	/ /		/ /																						
Alice Wonderland	8/19/97	1	7/25/03		X																				
	/ /		/ /																						
Sarah Lee	3/22/93	5	7/26/98			X															M				
	/ /		/ /																						
John Wilson	9/11/94	4	7/26/98	X																					
	/ /		/ /																						
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Mark an (X) in column of missing vaccine dose(s)

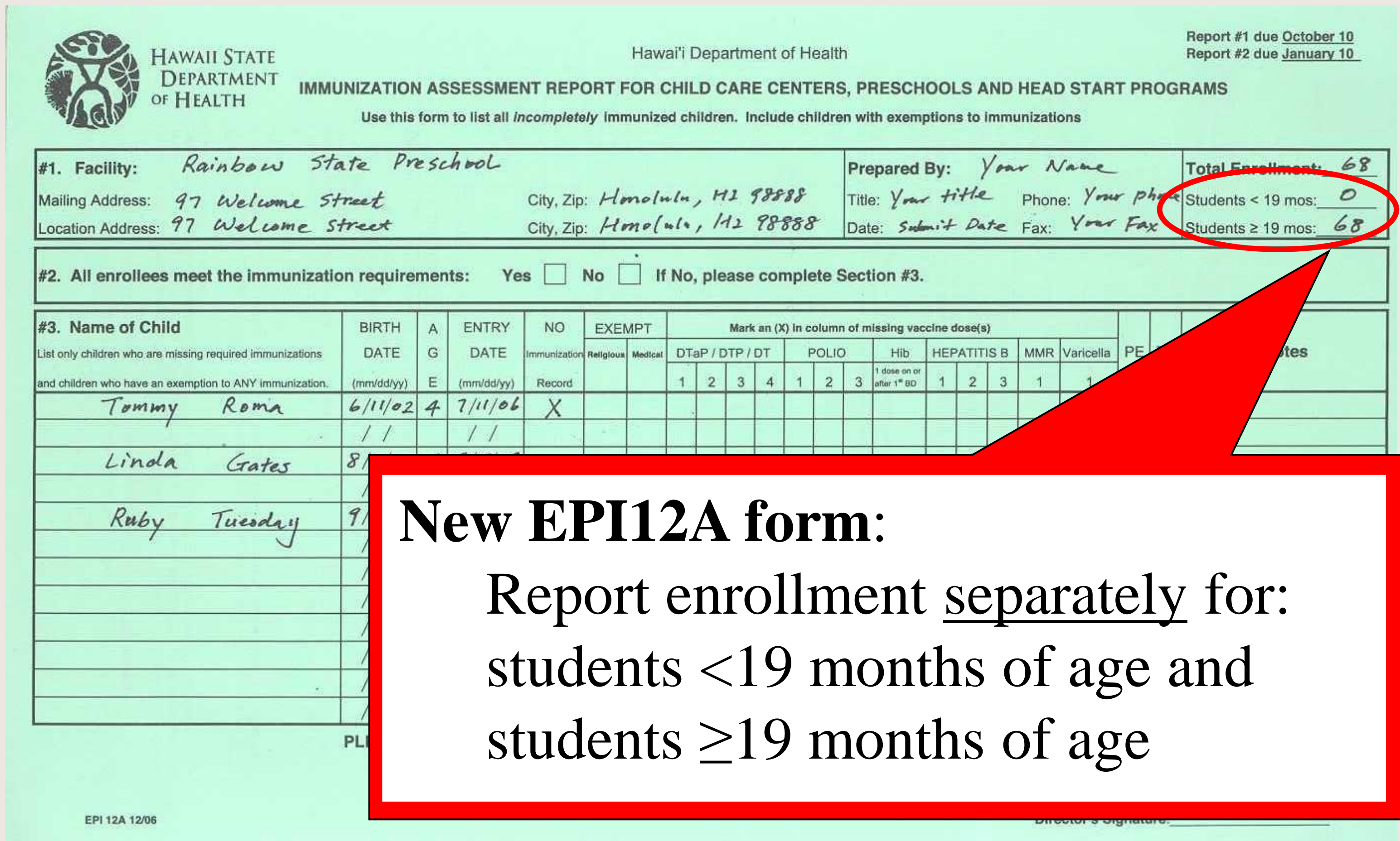
PLEASE READ INSTRUCTIONS ON THE REVERSE SIDE BEFORE COMPLETING THIS REPORT

EPI 12B 12/06

Principal's / Director's Signature: ____________

A Sample of a Final Report - EPI 12A

(Preschool, Head Start and Child Care Centers)



Hawaii State Department of Health

Hawai'i Department of Health

Report #1 due October 10
Report #2 due January 10

IMMUNIZATION ASSESSMENT REPORT FOR CHILD CARE CENTERS, PRESCHOOLS AND HEAD START PROGRAMS

Use this form to list all *incompletely* immunized children. Include children with exemptions to immunizations

#1. Facility: Rainbow State Preschool
Mailing Address: 97 Welcome Street City, Zip: Honolulu, HI 98888
Location Address: 97 Welcome Street City, Zip: Honolulu, HI 98888
Prepared By: Your Name
Title: Your title Phone: Your phone
Date: Submit Date Fax: Your Fax
Total Enrollment: 68
Students < 19 mos: 0
Students ≥ 19 mos: 68

#2. All enrollees meet the immunization requirements: Yes ☐ No ☐ If No, please complete Section #3.

#3. Name of Child
List only children who are missing required immunizations and children who have an exemption to ANY immunization.

Name of Child	BIRTH DATE (mm/dd/yy)	AGE	ENTRY DATE (mm/dd/yy)	NO Immunization Record
Tommy Roma	6/11/02	4	7/11/06	X
Linda Gates	8/			
Ruby Tuesday	9/			

EPI 12A 12/06

Reporting Requirement
Immunization Assessment Report (EPI 12)

Reporting Requirements

- **All schools must Submit Immunization Assessment Reports (EPI 12 reports) to the Department of Health by October 10th and January 10th including the names of all students:**
  - **Provisionally admitted**
  - **Excluded for failure to comply with immunization & examination requirements**
  - **Medical & Religious exemptions**
- **Report must include the missing immunizations and dose numbers**

EPI 12A and EPI 12B Forms:

Hawaii State Department of Health

Hawai'i Department of Health

Report #1 due October 10
Report #2 due January 10

IMMUNIZATION ASSESSMENT REPORT FOR CHILD CARE CENTERS, PRESCHOOLS AND HEAD START PROGRAMS

Use this form to list all *incompletely* immunized children. Include children with exemptions to immunizations

#1. Facility:		Prepared By:		Total Enrollment:
Mailing Address:	City, Zip:	Title:	Phone:	Students < 19 mos:
Location Address:	City, Zip:	Date:	Fax:	Students ≥ 19 mos:

#2. All enrollees meet the immunization requirements: Yes ☐ No ☐ If No, please complete Section #3.

#3. Name of Child List only children who are missing required immunizations and children who have an exemption to ANY immunization.	BIRTH DATE (mm/dd/yy)	AGE	ENTRY DATE (mm/dd/yy)	NO Immunization Record	EXEMPT Religious	EXEMPT Medical	DTaP / DTP / DT 1	2	3	4	POLIO 1	2	3	Hib 1 dose on or after 1st BD	HEPATITIS B 1	2	3	MMR 1	Varicella 1	PE	TB	Notes
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Report due day

EPI 12A: Preschool, Head Start and Child Care Centers

Hawaii State Department of Health

Hawai'i Department of Health

Report #1 due October 10
Report #2 due January 10

IMMUNIZATION ASSESSMENT REPORT FOR PUBLIC and PRIVATE SCHOOLS

Use this form to list all *incompletely* immunized students, grades K-12. Include students with exemptions to immunizations.

#1. School:		Prepared By:		Enrollment	Does this school have a pre-k program? Yes ☐ No ☐
Mailing Address:	City, Zip:	Title:	Phone:	Kindergarten: ____	If YES, please complete the Immunization Assessment
				Other grades (___ to ___): ____	Report for CHILD CARE CENTERS, PRESCHOOLS
Location Address:	City, Zip:	Date:	Fax:	Total enrollment: ____	AND HEAD START Programs (EPI12A).
				7th Grade enrollment only: ____	Do not list pre-k students on this form.

#2. All enrollees meet the immunization requirements: Yes ☐ No ☐ If No, please complete Section #3.

#3. Name of Student List only students who are missing required immunizations and students who have an exemption to ANY immunization	BIRTH DATE (mm/dd/yy)	GRADE	ENTRY DATE (mm/dd/yy)	NO Immunization Record	EXEMPT Religious	EXEMPT Medical	DTaP / DTP / DT / Td 1	2	3	4	5	POLIO 1	2	3	4	HEPATITIS B 1	2	3	MMR 1	2	Varicella 1	2	PE	TB	Notes
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PLEASE READ INSTRUCTIONS ON THE REVERSE SIDE BEFORE COMPLETING THIS REPORT

EPI 12B 12/06

Principal's / Director's Signature: ____________

Report due day

EPI 12B: Grades K-12

How to Order Forms

EPI 6 Form (Request for Forms)

REQUEST FOR FORMS

Section/School________________________________

Contact Name________________________________

Phone___________________ Island_____________

Date Requested__________ Pick-up Date_________

State of Hawaii Department of Health
Immunization Branch
P. O. Box 3378
Honolulu, HI 96801
Attn.: Assessment and Technical Support Section

Tel: 586-8313 Fax: 586-7511

Item	Material Name	Quantity
Haw 15	Hawaii Administrative Rules, Chapter 157	
Brochure	Important Notice to Parents - School Health Requirements (Available in English, Ilokano, Tagalog, Marshallese, Samoan & Japanese, Chinese, Korean, Spanish, Tongan, Vietnamese)	
EPI 06	Request for Forms	
EPI 07	Request for Exemption from Immunization on Religious Grounds	
EPI 10A	Notice of Incomplete Health Requirements (Available in English, Tongan, Ilokano, Tagalog, Marshallese & Samoan)	
EPI 10B	Provisional Entrance Notice (Available in English, Tongan, Ilocano, Tagalog, Marshallese & Samoan)	
EPI 10C	Notice of Incomplete Immunization Requirements For 7th Grade Attendance	
EPI 10D	Notice of Exclusion (Available in English, Tongan, Ilokano, Tagalog, Marshallese & Samoan)	
EPI 12A	Immunization Assessment Report for Child Care Centers, Preschools, and Head Start Programs	
EPI 12B	Immunization Assessment Report for Public and Private Schools (K-12)	
7th Grade Yellow Card	7th Grade Student Immunization Record	

Order Form Revised 4/2007
EPI 06

Online Immunization Assessment Reporting System

- **Access the website:**
  https://immunization.doh.hawaii.gov/HIMedIC
  (Need to register first!)

- **Access the User Manual:**
  - **Go to vaxhawaii.com**
    1. **Click on: School Health Requirements**
    2. **Click on: School Online Reporting System User Manual**

- **Call ATSS at (808)586-8313 for further assistance or technical support**

Contact Information

- **Immunization Branch:**
  - ATSS: 586-8313
  - Neighbor Islands: 1-800-933-4832
  - ATSS Fax: (808) 586-7511
  - Web Site: www.vaxhawaii.com
- **Tuberculosis Control Branch:**
  - (808) 832-5731
  - TB Information Line (808) 832-5738
  - Web Site: www.hawaii.gov/health/tb

Thank You!