KANSAS IMMUNIZATION REQUIREMENTS

Based on age of child as of September 1 of current school year.

Ages 0-4 Recommended Schedule

Birth	**HEP B**
2 Months	**DTP/DTaP/DT** **POLIO** **HEP B** **HIB** **PCV7**
4 Months	**DTP/DTaP/DT** **POLIO** **HIB** **PCV7**
6 Months	**DTP/DTaP/DT** **POLIO** **HEP B** **HIB** **PCV7**
12-15 Months	**DTP/DTaP/DT** **MMR** **VAR** **HIB** **PCF7**

Recommendations are based on the ACIP Recommended Schedule. For copies, call 785-296-5591.

Ages 5-6

4 Doses of DTP/DTaP/DT**

a) There must be a minimum of 4 weeks between doses, with 6 months between the 3rd and 4th dose.
b) At least one dose must be on or after the 4th birthday.
c) If 4th dose is administered before the 4th birthday, a booster 5th dose must be given at 4-6 years of age.

** If <12 months old when 1st dose of DT is given, child should receive a total of 4 primary DT doses.
** If 12 months of age or older at time of 1st dose of DT, a 3rd dose 6-12 months after 2nd dose completes primary series.
** Acceptable only when Pertussis component is contraindicated by a physician

All IPV or OPV Schedule
4 doses of POLIO are acceptable IF:
a) There is a minimum of 4 weeks between each dose, regardless of age given.
3 doses of POLIO are acceptable IF:
a) There is a minimum of 4 weeks between each dose, with 1 dose given on or after the 4th birthday.

IPV/OPV Combination Schedule
4 doses of POLIO are acceptable IF:
a) There is a minimum of 4 weeks between each dose, regardless of age given. Three doses of a combination schedule are NOT acceptable.

2 doses of MMR
a) The 1st dose must be on or after the 1st birthday.
b) There must be 4 weeks between 1st and 2nd dose.

1 dose of VAR (Required for Kindergarten and First Grade entry for 2005-06 school year)
a) Must be on or after the 1st birthday.
b) Not needed if varicella disease verified.

3 doses of HEP B (Required for Kindergarten and First Grade entry for 2005-06 school year)
a) There is a minimum of 4 weeks between 1st and 2nd doses.
b) The 3rd dose must be given at least 4 months after the 1st dose.
c) If the 3rd dose was given in infancy, the infant must have been at least 24 weeks of age.

Ages 7-18

3 doses of Td
a) There must be a minimum of 4 weeks between doses, with 6 months between the 2nd and the 3rd dose.
b) The Td booster is required 10 years after completion of the DTP/DTaP/DT/Td primary series. The first booster may be given as early as 11-12 years of age if at least 5 years after the last DTP/DTaP/DT/Td. If a dose is given sooner as part of wound management, the next booster is not needed for 10 years.

All IPV or OPV Schedule
4 doses of POLIO are acceptable IF:
a) There is a minimum of 4 weeks between each dose, regardless of age given.
3 doses of POLIO are acceptable IF:
a) There is a minimum of 4 weeks between each dose, with 1 dose given on or after the 4th birthday.

IPV/OPV Combination Schedule
4 doses of POLIO are acceptable IF:
a) There is a minimum of 4 weeks between each dose, regardless of age given. Three doses of a combination schedule are NOT acceptable.

2 doses of MMR
a) The 1st dose must be on or after the 1st birthday.
b) There must be 4 weeks between 1st and 2nd dose.

- Varicella vaccine is not necessary for individuals who have had the disease.
- Single antigen measles vaccine will not meet requirements without the addition of mumps and rubella vaccine.
- The limit for DTP vaccine is 6 doses, and the limit for POLIO vaccine is 5 doses, regardless of schedule.
- Tetanus toxoid alone will not meet the Td 10-year booster requirement.
- Half doses or reduced doses of vaccine are not acceptable.
- Immunizations started before 6 weeks of age are not considered valid, except for Hepatitis B vaccine.

PARENTS AND/OR GUARDIANS ARE NOT AUTHORIZED TO COMPLETE KCI FORMS.
Must be documented by a physician, their office personnel, a health department representative, or a designated school representative. Parents or guardians may complete the religious exemption section only.

1. Medical Exemption signed by a Medical Doctor (M.D.) or a Doctor of Osteopathy (D.O.)

Medical License #_____ State of Licensure_____

Signature_____ Date of Licensure_____

Name (print)_____ Telephone Number (_____)_____

2. Religious Exemption signed by the Parent or Guardian.

Signature_____ Date_____ Relationship_____

A ROSTER WITH THE NAMES OF ALL EXEMPT STUDENTS SHOULD BE MAINTAINED. THE PARENTS OR GUARDIANS OF EXEMPT CHILDREN SHOULD BE INFORMED THAT THEIR CHILDREN SHALL BE EXCLUDED FROM SCHOOL IN THE EVENT OF AN OUTBREAK OR SUSPECTED CASE OF A VACCINE-PREVENTABLE DISEASE.

KANSAS CERTIFICATE OF IMMUNIZATION (KCI)

This record is part of the student's permanent record and shall be transferred from one school to another as defined in Section 72-5209 (d) of the Kansas School Immunization Law (amended 1994.)

Student Name_____ Sex: M ☐ F ☐ Birthdate:_____-_____-_____

Name of Parent or Guardian_____ Address_____

Telephone Number (_____)_____ City _____ State_____ Zip Code_____ County_____

VACCINE	RECORD THE MONTH, DAY, AND YEAR THAT EACH DOSE OF VACCINE WAS RECEIVED																					
	1st			2nd			3rd			4th			5th			6th			7th		
DTP, DTaP and/or DT/Td[i] (Diphtheria, Tetanus, and Pertussis; acellular Pertussis; or Tetanus and Diphtheria only) Required for school entry. **Circle type**	DT	DTaP	Td	DT	DTaP	Td	DT	DTaP	Td	DT	DTaP	Td	DT	DTaP	Td	DT	DTaP	Td	DT	DTaP	Td
	-	-		-	-		-	-		-	-		-	-			-	-		-	-
OPV or IPV (Polio) Required for school entry. **Circle type**	OPV		IPV	OPV		IPV	OPV		IPV	OPV		IPV	OPV		IPV						
	-	-		-	-		-	-		-	-		-	-							
HEP B (Hepatitis B) Required for Kindergarten and First Grade entry for 2005-06 school year. Recommended for all children.	-	-		-	-		-	-													
Varicella (Chicken Pox) Required for Kindergarten and First Grade entry for 2005-06 school year. Recommended for all children.	-	-		-	-		**Date of Illness:** _____ **Parent/Physician Signature:**														
MMR (Measles, Mumps, and Rubella combined) Required for school entry.	-	-		-	-																
Measles Rubella Mumps (Single Antigen Doses Only) **Circle Antigen**	-	-		-	-																
HIB (Haemophilus Influenzae Type B) Recommended; not required for school entry.	-	-		-	-		-	-		-	-										
PCV7 (Pneumococcal Conjugate) Recommended; not required for school entry.	-	-		-	-		-	-		-	-										
HEP A (Hepatitis A) Recommended for selected populations; not required for school entry.	-	-		-	-																

If additional doses are added, please initial the dose and sign below:

_____

_____

_____

_____

DOCUMENTATION

PARENTS AND/OR GUARDIANS ARE NOT AUTHORIZED TO COMPLETE KCI FORM.

I certify I reviewed this student's vaccination record and transcribed it accurately.

Signature_____ Agency_____

Name & Title (Printed)_____

The record presented was: Date_____-_____-_____

☐ Pink Kansas Immunization Record

☐ Other Immunization record (Specify_____)

LEGAL ALTERNATIVES TO VACCINATION REQUIREMENTS

☐ 1. Annual Medical Exemption: A Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) must complete the information below, as well as the affidavit on the reverse side. Yearly medical exemptions shall be documented on KCI Form B and attached to this record.

* If DT is given prior to 7 years of age, a Yearly Medical Exemption is required.

☐ DTaP ☐ Pertussis only ☐ MMR ☐ Other_____

☐ IPV ☐ HEP B ☐ Varicella

☐ 2. Religious Exemption: Parent or guardian must complete the affidavit on the reverse side.

KANSAS IMMUNIZATION PROGRAM
1000 SW Jackson, Suite 210, Topeka, KS 66612-1274
PHONE 785-296-5591 FAX 785-296-6510
WEB SITE www.kdhe.state.ks.us/immunize

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