FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

April 30, 2021

Dear Parents,

As hard as it is to believe, the end of the school year is right around the corner! That means that it's time to start thinking about what comes next for the fall of 2021. I would like to provide you with a few reminders that will help answer any questions with your registration.

Current SAGE participants can register starting on **MAY 3**. Open Registration begins on **MAY 17**. From May 3-12, all enrollment forms must be emailed to Tami Mastroianni. Please save the document with your child's name as the file name and email the completed form to Tammi at tmastroianni@wallingfordymca.org.

If you enroll from May 3-May 12, the REGISTRATION FEE WILL BE WAIVED! On May 13, a $25/family non-refundable registration fee will be charged. This registration fee will increase to $50 on June 12. This fee is not applied to your SAGE balance.

Attached to this letter is your packet for the 2021-2022 school year. The listed information below must be fully completed and signed upon registration:

ENROLLMENT FORM
AUTOMATIC DRAFT FORM

Health forms **MUST** be in by AUGUST 15. Per state regulations, a current physical (within one year) is required at the beginning of each school year. If your child has an Epi-pen, inhaler, or any other medication that is needed while at the SAGE program, an Authorization to Administer Medication packet MUST be submitted with your child's physical. All required medications should be brought to the program on your child's first day. **Your child may not start the program until a current physical and any necessary medication administration forms are on file.**

Transportation forms must be completed on your Parent Portal.

Accounts are billed monthly and are paid in **10 equal payments** from **September-June**. We will **NOT** adjust the payment for vacations. A minimum of 3 days per week is required. All financial assistance applicants (current & new) will need to complete a new packet for this school year.

ALL CONTRACTS MUST BE RECEIVED BY 5:00PM ON AUGUST 25, 2021 TO START ON THE FIRST DAY OF SCHOOL, AUGUST 30. All contracts received after 5:00PM on August 25 will require 3 business days before your child may start the program.

Hope you have a wonderful summer and see you in the fall! Please feel free to contact me with any questions about the program.

Sincerely,

EMILY WALTER
Director of Childcare Services
ewalter@wallingfordymca.org

WALLINGFORD FAMILY YMCA
81 S Elm Street, Wallingford CT 06492
P 203 269 4497 **F** 203 284 0572 www.wallingfordymca.org

the YMCA

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

SAGE & ELMS 2021-2022 ENROLLMENT FORM

CHILD

NAME | DOB | ☐ M ☐ F

ADDRESS | CITY/ST/ZIP

SCHOOL | GRADE (2021-2022 SCHOOL YEAR) | AGE

FAMILY DATA

PARENT/GUARDIAN #1 | HOME PHONE

HOME ADDRESS | CELL PHONE

PLACE OF EMPLOYMENT | WORK PHONE

EMPLOYMENT ADDRESS | CITY/ST/ZIP

EMAIL ADDRESS

PARENT/GUARDIAN #2 | HOME PHONE

HOME ADDRESS | CELL PHONE

PLACE OF EMPLOYMENT | WORK PHONE

EMPLOYMENT ADDRESS | CITY/ST/ZIP

EMAIL ADDRESS

Child Primarily Resides With: ☐ **P/G 1** ☐ **P/G 2** ☐ **Both** ☐ **Other**_____

MEDICAL

DOES YOUR CHILD HAVE ANY ALLERGIES, MEDICATIONS, PHYSICAL/EMOTIONAL DIFFICULTIES, AND/OR MEDICAL CONDITIONS ?

PLEASE NOTE: If your child has any medication that may be needed (i.e. Epi-Pen, inhaler), you MUST submit an "Authorization to Administer Medication" form and bring the medication to the program on your child's first day.

PHYSICIAN NAME | PHONE

OTHER

*** It is our hope that every participant in SAGE feels safe, secure & understood. If there is any additional information about your child that you feel you should share so we can achieve this goal, please let us know in the space below: ***

Does your child have an IEP or 504? ☐ **Yes** ☐ **No**

EMERGENCY CONTACTS

PERSONS TO BE NOTIFIED IN CASE OF EMERGENCY (WHEN PARENTS CANNOT BE REACHED) - TWO REQUIRED

NAME | PHONE 1 | PHONE 2 | RELATIONSHIP

NAME | PHONE 1 | PHONE 2 | RELATIONSHIP

NAME | PHONE 1 | PHONE 2 | RELATIONSHIP

PERSONS TO WHOM CHILD MAY BE RELEASED TO (OTHER THAN PARENTS/GUARDIANS)

NAME | PHONE 1 | PHONE 2 | RELATIONSHIP

NAME | PHONE 1 | PHONE 2 | RELATIONSHIP

NAME | PHONE 1 | PHONE 2 | RELATIONSHIP

PERSONS TO WHOM CHILD MAY NOT BE RELEASED (MUST PROVIDE DOCUMENTATION)

NAME | RELATIONSHIP

FULL TIME (4/5 DAYS)

☐ **SAGE AM CARE ONLY**
(6:45-9:00AM at School Site)

Members: **$256** ($13.99/day)
Program Members: **$312** ($17.05/day)

☐ **SAGE PM CARE ONLY**
(3:30-6:00PM at School Site)

Members: **$322** ($17.61/day)
Program Members: **$373** ($20.37/day)

☐ **SAGE AM & PM CARE**
(6:45-9:00AM & 3:30-6:00PM at School Site)

Members: **$530** ($28.96/day)
Program Members: **$642** ($35.08/day)

☐ **ELMS**
(2:40-6:00PM at YMCA)

Members: **$365** ($19.95/day)
Program Members: **$440** ($24.04/day)

PART TIME (3 DAYS)

☐ **SAGE AM CARE ONLY**
(6:45-9:00AM at School Site)
Days Attending ☐**M** ☐**T** ☐**W** ☐**R** ☐**F**
Members: **$185** ($15.81/day)
Program Members: **$226** ($19.32/day)

☐ **SAGE PM CARE ONLY**
(3:30-6:00PM at School Site)
Days Attending ☐**M** ☐**T** ☐**W** ☐**R** ☐**F**
Members: **$236** ($20.19/day)
Program Members: **$283** ($24.19/day)

☐ **SAGE AM & PM CARE**
(6:45-9:00AM & 3:30-6:00PM at School Site)
Days Attending ☐**M** ☐**T** ☐**W** ☐**R** ☐**F**
Members: **$393** ($33.59/day)
Program Members: **$469** ($40.09/day)

☐ **ELMS**
(2:40-6:00PM at YMCA)
Days Attending ☐**M** ☐**T** ☐**W** ☐**R** ☐**F**
Members: **$278** ($23.76/day)
Program Members: **$348** ($29.74/day)

PLEASE NOTE: Prices listed are **MONTHLY** and based on **10 MONTHS**
If you have another child attending the SAGE program AM & PM Full Time, a 10% sibling discount will be applied to that child.

☐ **Use account on file:** Last 4 Digits of Card/Account: _____ Signature: _____

CHILD'S START DATE _____
Please write specific date.
(must be at least **3 business days** from date of registration)

A Bus Transportation Form **MUST** be filled out in your parent portal.
If your child is a student at Moran Middle School, they will be bused to the YMCA ELMS After School Program by Durham School Services. By signing below, you authorize this transportation service.

PLEASE READ CAREFULLY BEFORE SIGNING. SIGNATURE IS REQUIRED FOR APPLICATION.

- I will provide an up-to-date immunization record and health examination form prior to my child's start date.
- Tuition payments are due monthly by the 5th of the month. A $25 late fee will be assessed to past due accounts and your child's enrollment in the program will be jeopardized.
- I give permission for the program to use without limitation or obligation my child's photograph or film footage, which may include images or voice recordings on social media and in YMCA promotional materials.
- I agree that the Wallingford Family YMCA participant will uphold and abide by the rules and regulations adopted by the Wallingford Family YMCA and the SAGE/ELMS Program and I recognize that they reserve the right to dismiss or suspend the participants at any time if, in the judgment of the Director of the program, such action is in the best interest of the program.
- I do hereby assume full responsibility for any and all damages, injuries, or losses that my child may sustain or incur, if any, while attending or participating in the SAGE/ELMS program, whether on or off-site. I/we hereby waive all claims against the Wallingford Family YMCA, its agents, staff, or partners of said program, individually, or otherwise, for any and all claims for injuries or damages that my child may sustain. I/We understand that there is a risk of injury associated with participation in any YMCA program and I/we certify that my child is in good physical condition and has no disabilities or other ailments that might hamper his/her participation.
- I give permission for emergency medical care, emergency surgery and/or anesthesia to be administered to my child in the event that I can not be reached. Should my child need to be transported to any Emergency Room, I give permission for an ambulance to be called and will be responsible for payment of this transportation.
- I give permission for my child to attend field trips to Doolittle Park, the Rotary/YMCA Teen Center, the YMCA KinderHouse, and the Wallingford Family YMCA for activities. I understand that my child will walk to and from each activity. **(ELMS ONLY)**

I, the undersigned, swear that the information provided in this application is true as of the date noted. I agree to notify the YMCA in writing immediately if any information on this application changes while my/our child is in the YMCA SAGE/ELMS Program.

PRINTED NAME SIGNATURE DATE

PRINTED NAME SIGNATURE DATE

DRAFT FORM

WALLINGFORD FAMILY YMCA MONTHLY DRAFT AUTHORIZATION

FOR STAFF USE ONLY

STAFF _____ DATE _____

☐ NEW ☐ CHANGE

MEMBER/PARTICIPANT NAME _____

PHONE _____

EMAIL _____

DRAFT FOR ☐ MEMBERSHIP ☐ CHILD CARE ☐ CAMP ☐ CSC ☐ SWIM TEAM ☐ PRIVATE LESSONS ☐ PT

SAVINGS OR CHECKING ACCOUNT

NAME _____
(AS IT APPEARS ON ACCOUNT)

BANK NAME _____

ROUTING # _____

ACCOUNT # _____

I authorize the Wallingford Family YMCA to access my checking or savings account for my monthly dues payment. I understand that the payment will be electronically transferred monthly from my account to the Wallingford Family YMCA.

A voided check must accompany the above information

_____
SIGNATURE OF ACCOUNT HOLDER

CREDIT/DEBIT CARD

NAME _____
(AS IT APPEARS ON CARD)

AMEX VISA MASTERCARD DISCOVER

__ __ __ __-__ __ __ __-__ __ __ __-__ __ __ __

EXPIRATION DATE _____

I authorize the Wallingford Family YMCA to access my credit card for my monthly dues payment. It is understood that the sending of a pre-authorized payment to the designated account as said payment becomes due, constitutes valid notice of such payment due on this account. When my issuing bank authorizes this transaction by charging the designated account, such an authorization will serve as a receipt for the payment.

_____
SIGNATURE OF CARD HOLDER

WALLINGFORD FAMILY YMCA MONTHLY DRAFT AGREEMENT

1. I understand that the draft authorizes a perpetual month to month payment from the above account. For membership payments, this draft does not expire and therefore automatically renews monthly. For camp, swim team, child care and personal training payments, this draft ends at the completion of the program. For Community Support Campaign payments, the draft ends at the receipt of your total gift amount.
2. If I wish to cancel or change my pre-authorized draft, a new **Draft Form** must be received by the Wallingford Family YMCA two (2) weeks before the next draft. If I wish to cancel my membership, the **Termination Form** must be received by the Wallingford Family YMCA on or before the 10th of the month to take effect the following month. All membership cards will be required to be turned in when the membership terminates. These forms are available at the Welcome Center or online at www.wallingfordymca.org.
3. Should any draft not be honored by my bank/credit card company for any reason, I realize that I am still responsible for payment and the following processing fees will be charged to my account: $15 for membership & personal training drafts and $25 for child care & camp drafts. If I fail to make the required payment, my membership or child care/camp spot may be revoked.
4. The Wallingford Family YMCA reserves the right to cancel my draft for which a draft is returned two (2) consecutive months or three (3) times over a six (6) month period. The Wallingford Family YMCA is not obligated to offer the draft option to anyone whose draft has been previously revoked.
5. The YMCA, at its discretion, may adjust the monthly rate for membership, personal training, child care & camp payments. Members & Program Members receive at least 30 days notice prior to any change.
6. I agree to immediately notify the Wallingford Family YMCA of any changes in my credit or bank account information that may affect payment of my draft.

YOUR STATEMENT WILL SHOW A CHARGE FROM "YOUNG MEN'S CHRISTIAN ASSOCIATION".

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND DURATION OF THE AGREEMENT

SIGNATURE _____ DATE _____

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

MONTHLY SAGE PAYMENT POLICY

Monthly payments are calculated by 183 days of school. We multiply the daily rate by 183 days and divide it into 10 equal months. **You will pay 10 equal months from September – June.**

If you withdrawal before June, you will be responsible for the number of days in the months that your child was enrolled. If your current payments do not cover the months attended, then you will be responsible for the difference. Two weeks notice is require for withdrawals. For example, if your child is a member and enrolled 5 days a week for AM Only Care, the rate is $256 per month, or $13.99 per day. If you leave as of December, you will have paid $1024. As your child was enrolled for 78 days, you would owe an additional $67.22 for the days attended:

$13.99 (Daily Rate) x 78 (Days Attended) = $1091.22 (Total Due)
$1091.22 (Total Due) – $1024 (Monthly Payment) = $67.22 (Remainder Due)

STATEMENTS
Monthly child care tuition statements are distributed the last week of each month.
This statement includes the monthly charge for the upcoming month.

PAYMENTS
Payments are due the 1st of each month. You can pay through automatic draft, by mail or in person at the Welcome Center.

AUTOMATIC DRAFT: Drafts are processed on the 5th of each month by a checking account or credit card.

IN PERSON: You are responsible to make your payment by the 5th of each month at the YMCA. The YMCA is open 7 days a week.

BY MAIL: Payment can by mailed to:
Wallingford Family YMCA
ATTN: Child Care Billing
81 S Elm Street
Wallingford CT 06492

Payments received after the 5th of the month are considered PAST DUE. A written notification and a late fee of $25 will be applied to your balance. Your child/ren may not return to the program until full payment has been received.

Child care accounts MUST be current prior to enrolling in any other YMCA programs.

FINANCIAL ASSISTANCE
Financial assistance is available through the Wallingford Family YMCA and the State of Connecticut's Care 4 Kids program. Applications are available at the YMCA Welcome Center.

WALLINGFORD FAMILY YMCA
CHILD CARE BILLING
81 S Elm Street, Wallingford CT 06492
P 203 269 4497 x114 **F** 203 284 0572 www.wallingfordymca.org

State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	❑ Black, not of Hispanic origin
Primary Care Provider	❑ American Indian/ Alaskan Native	❑ White, not of Hispanic origin
	❑ Hispanic/Latino	❑ Asian/Pacific Islander
		❑ Other
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N Does your child have dental insurance? Y N	If your child does not have health insurance, call **1-877-CT-HUSKY**	

* If applicable

Part I — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***Speech** (school entry only)	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____
Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 4/2017

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Exemption: Religious _____ **Medical:** Permanent _____ Temporary _____ **Date:** _____

Renew Date: _____ _____ _____ _____

Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.
Medical exemptions that are temporary in nature must be renewed annually.

Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number