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GANEINU REGISTRATION FORM 2024-2025

INSTRUCTIONS

To submit registration for your child at Ganeinu for the 2024/25 academic year:

- Parents/Guardians must fill out and sign the (1) Ganeinu Registration Form.
- Both parents/guardians and child's pediatrician must fill out and sign the (2) General Health Appraisal Form, as well as the
- (3) Certificate of Immunization Form (or either the (4) Medical or (5) Non-Medical Exemption Forms).

Your pediatrician may have his/her own version of the General Health Appraisal Form as well as Certificate of Immunization. These are acceptable for admission to Ganeinu.

Please return all completed forms with $250 application fee to ganeinuofficemanagement@gmail.com or mail to Ganeinu Preschool, 428 South Forest Street, Denver, CO 80246. Registration fee may be paid by check or via PayPal at https://GaneinuDenver.org/payment.

You may request a tour of the Ganeinu facility, or print additional registration or medical forms at https://GaneinuDenver.org/register.

Question? Please contact Ganeinu Director, Elka Popack at 720-224-8484.

ALL FORMS MUST BE SIGNED AND SUBMITTED BEFORE YOUR CHILD WILL BE ALLOWED TO ATTEND GANEINU.

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GANEINU REGISTRATION FORM 2024-2025

Date of Registration_____/_____/_____ Registration Fee **$250**

CHILD'S INFORMATION

Last Name _____ First _____ Middle_____

Nickname_____ Date of Birth _____/_____/_____

Address _____

City_____ State_____ Zip _____

PARENTS/GUARDIANS INFORMATION

PARENT/GUARDIAN 1

Last Name _____ First _____ Cellphone ( ) _____-_____

Home phone ( ) _____-_____ Email address_____

Employer _____

Employer Address_____

City_____ State_____ Zip _____

Employer phone ( ) _____-_____ Ext._____

PARENT/GUARDIAN 2

Last Name _____ First _____ Cellphone ( ) _____-_____

Home phone ( ) _____-_____ Email address_____

Employer _____

Employer Address_____

City_____ State_____ Zip _____

Employer phone ( ) _____-_____ Ext._____

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GANEINU REGISTRATION FORM 2024-2025

EMERGENCY CONTACTS INFORMATION

EMERGENCY CONTACT 1

Last Name _____ First _____ Relationship_____

Cell phone ( ) _____ - _____ Home phone ( ) _____ - _____

Email address_____

Address _____

City_____ State_____ Zip _____

EMERGENCY CONTACT 2

Last Name _____ First _____ Relationship_____

Cell phone ( ) _____ - _____ Home phone ( ) _____ - _____

Email address_____

Address _____

City_____ State_____ Zip _____

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GANEINU REGISTRATION FORM 2024-2025

WHO ELSE IS AUTHORIZED TO PICK UP YOUR CHILD FROM SCHOOL?

AUTHORIZED PERSON 1

Last Name _____ First _____ Relationship_____

Cell phone ( ) _____ - _____ Home phone ( ) _____ - _____

Email address_____

Address_____

City_____ State_____ Zip _____

AUTHORIZED PERSON 2

Last Name _____ First _____ Relationship_____

Cell phone ( ) _____ - _____ Home phone ( ) _____ - _____

Email address_____

Address_____

City_____ State_____ Zip _____

MEDICAL INFORMATION

Child's Doctor_____Phone ( ) _____ - _____

Address_____

City_____ State_____ Zip _____

GANEINU REGISTRATION FORM 2024-2025

MEDICAL INFORMATION (continued)

Child's Dentist_____ Phone ( ) _____ - _____

Address_____

City_____ State_____ Zip _____

Health Care Facility_____ Phone ( ) _____ - _____

Insurance_____ Phone ( ) _____ - _____

Has your child received a hearing screening? Y☐ N☐ Vision screening? Y☐ N☐ Dental screening? Y☐ N☐

Has your child ever had any of the following illnesses:

Ear infection	Y☐ N☐	Asthma	Y☐ N☐	Chicken Pox	Y☐ N☐
Diabetes	Y☐ N☐	Nosebleeds	Y☐ N☐	Flu	Y☐ N☐
Heart disease/defect	Y☐ N☐	Measles	Y☐ N☐	Other: _____	
Convulsions/seizures	Y☐ N☐	Mumps	Y☐ N☐	_____	

Does your child have allergies or reactions to any of the following?

Hay fever	_____	Other drugs	_____
Plants	_____	Animals	_____
Insect stings or bites	_____	Food	_____
Penicillin	_____	Other	_____

Has your child had any surgeries or serious injuries? (Please include dates.)

_____

_____

Does your child take any medications? Y☐ N☐ Please specify:

_____

Physical Limitations_____

GANEINU REGISTRATION FORM 2024-2025

MEDICAL INFORMATION (continued)

Dietary Limitations_____

Visual Limitations_____

Hearing Limitations_____

Chronic Illnesses/Special Needs _____

Are there any activities in which you prefer that your child NOT participate?

_____

We need the following UPDATED documents filled-out by your pediatrician before your child can attend Ganeinu:

- **Certificate of Immunization (or Certificate of Medical Exemption or Certificate of Non-Medical Exemption).**
- **General Health Appraisal Form**

You may obtain blank copies of these documents at GaneinuDenver.org/register
Please email them to ganeinuofficemanagement@gmail.com or mail them to: Ganeinu Preschool, 428 S. Forest St., Denver, CO 80246

AUTHORIZATION FOR EMERGENCY MEDICAL CARE AND TRANSPORTATION

In the event of an emergency, I hereby give my permission for the childcare staff to access emergency medical services for my child _____ including transportation to the nearest health care facility, to receive emergency medical or surgical care and treatment. It is understood that the childcare provider will make a conscientious effort to locate the parents/guardians and emergency contacts listed on the registration document before any action will be taken. If it is not possible to locate parents/guardians or emergency contacts, treatment will not be delayed. I/we will accept the expense of emergency transportation, medical or surgical treatment.

Parent/Guardian Signature _____Date _____

Parent/Guardian Signature _____Date _____

AUTHORIZATION TO APPLY DIAPER CREAM

I hereby give permission to Ganeinu to apply the following diaper cream/ointment to my child _____:

☐ _____ or ☐ any diaper cream/ointment.

Parent/Guardian Signature _____Date _____

Parent/Guardian Signature _____Date _____

GANEINU REGISTRATION FORM 2024-2025

AUTHORIZATION TO APPLY SUNSCREEN

OPTION 1:

☐ I recognize that too much sunlight may be hazardous to my child's health. Therefore, I hereby give permission for the Ganeinu staff to apply sunscreen from *Rocky Mountain Sunscreen* to my child.

☐ I further agree that sunscreen may be applied to all exposed skin.

☐ I have checked all applicable information regarding the type and use of sunscreen for my child.

☐ I have consulted with my child's physician and do not know of any allergies or allergic reactions my child may have to this sunscreen.

OPTION 2:

If you choose to send your own sunscreen:

☐ I give permission for Ganeinu staff to apply this sunscreen to my child: _____

OPTION 3:

☐ No. For medical reasons, please do not apply any sunscreen to my child under any circumstances.

Parent/Guardian Signature _____Date _____

Parent/Guardian Signature _____Date _____

AUTHORIZATION FOR VIDEO AND COMPUTER VIEWING

I hereby give permission for my child _____ to view videos and computer programs deemed appropriate by Ganeinu.

Parent/Guardian Signature _____Date _____

Parent/Guardian Signature _____Date _____

GANEINU REGISTRATION FORM 2024-2025

AUTHORIZATION TO USE CHILD'S PICTURES OR VIDEOS

I hereby give permission to Ganeinu to take and use pictures and videos of my child _____ in all marketing materials, including but not limited to website, social media, newspapers and fliers.

Parent/Guardian Signature _____Date _____

Parent/Guardian Signature _____Date _____

AUTHORIZATION TO GO ON WALKING FIELD TRIPS

I hereby give permission for my child _____ to go on neighborhood walking trips, including, but not limited to, all children's programs at Chabad House at 400 South Holly Street.

Parent/Guardian Signature _____Date _____

Parent/Guardian Signature _____Date _____

POLICIES AND PROCEDURES AGREEMENT

I have received the Ganeinu Parent Handbook outlining all of Ganeinu's policies and procedures. I have read the Handbook, and I agree to follow, accept the conditions of, and give authorization and approval for the activities described in the policies and procedures.

Parent/Guardian Signature _____Date _____

Parent/Guardian Signature _____Date _____

GENERAL HEALTH APPRAISAL FORM

PARENT please complete AND SIGN

Child's Name:_____ **Birthdate:** _____

Allergies: ❑ None or Describe_____

Type of Reaction _____

Diet: ❑ **Breast Fed** ❑ **Formula** _____ ❑**Age Appropriate**

❑**Special Diet** _____

Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep.

❑ **Preventive creams/ointments/sunscreen may be applied as requested in writing by parent unless skin is broken or bleeding.**

I, _____ give consent for my child's care health provider, school child care or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (& applicable attachments) to my child's school, child care or camp personnel. FAX #: _____ DATE: _____

Parent/Guardian Signature_____

HEALTH CARE PROVIDER: Please Complete After Parent Section Completed

Date of Last Health Appraisal: _____ **Weight @ Exam:** _____

Physical Exam: ❑ **Normal** ❑ **Abnormal** (Specify any physical abnormalities)_____

Allergies: ❑ None or Describe_____ Type of Reaction _____

Significant Health Concerns: ❑Severe Allergies ❑Reactive Airway Disease ❑Asthma ❑Seizures ❑Diabetes ❑Hospitalizations ❑Developmental Delays ❑Behavior Concerns ❑Vision ❑Hearing ❑Dental ❑Nutrition ❑ Other _____

Explain above concern (if necessary, include instructions to care providers): _____

Current Medications/Special Diet: ❑ None or Describe _____

Separate medication authorization form is required for medications given in school, child care or camp

For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization) PLEASE CHOOSE ONE PRODUCT

❑Acetaminophen (Tylenol) may be given for pain or fever over 102 degrees every 4 hours as needed

Dose _____ or see the attached age-appropriate dosage schedule from our office

OR ❑Ibuprofen (Motrin, Advil) may be given for pain or for fever over 102 degrees every 6 hours as needed

Dose _____ or see the attached age-appropriate dosage schedule from our office

Immunizations: ❑Up-to-Date ❑ See attached immunization record ❑Administered today: _____

Health Care Provider: Complete if Appropriate

****ONLY REQUIRED BY EARLY HEAD START AND HEAD START PROGRAMS PER STATE EPSDT SCHEDULE****

**** Height @ Exam _____ ** B/P _____ **Head Circumference (up to 12 months) _____ ****

**** HCT/HGB _____ ** Lead Level ❑Not at risk or Level _____**

****TB ❑Not at risk or Test Results** ❑ Normal ❑ Abnormal

****Screenings Performed: ❑Vision:** ❑Normal ❑Abnormal **❑Hearing:** ❑Normal ❑Abnormal **❑Dental:** ❑Normal ❑Abnormal-

Recommended Follow-up_____

Provider Signature

Next Well Visit: ❑ Per AAP guidelines* or ❑ Age_____

This child is healthy and may participate in all routine activities in school sports, child care or camp program. Any concerns or exceptions are identified on this form.

_____

Signature of Health Care Provider (certifying form was reviewed) Date: _____

Office Stamp

Or write Name, Address, Phone, #

The Colorado Chapter of the American Academy of Pediatrics (AAP) and Healthy Child Care Colorado have approved this form. 04/07

*The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

COLORADO
Department of Public Health & Environment

Certificate of Immunization

6 CCR 1009—The Infant Immunization Program and Immunization of Students Attending School
Schools shall have on file an official Certificate of Immunization for every student enrolled.

COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH STUDENT ATTENDING COLORADO SCHOOLS

Name_____ **Date of Birth** _____

Parent/Guardian _____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION

Vaccine		Enter the month, day and year each immunization was given						Titer Date
Hep B	Hepatitis B							
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)							
DT	Diphtheria, Tetanus (pediatric)							
Tdap	Tetanus, Diphtheria, Pertussis							
Td	Tetanus, Diphtheria							
Hib	*Haemophilus influenzae* type b							
IPV/OPV	Polio							
PCV	Pneumococcal Conjugate							
MMR	Measles, Mumps, Rubella							
Measles	Measles							
Mumps	Mumps							
Rubella	Rubella							
Varicella	Chickenpox			Provider Documentation Date of Disease		Positive Screen Date		
Vaccines recorded below this line are recommended. Recording of dates is encouraged.								
HPV	Human Papillomavirus							
Rota	Rotavirus							
MCV4/MPSV 4	Meningococcal							
Hep A	Hepatitis A							
Flu	Influenza							
Other								

THIS SECTION CAN BE COMPLETED BY CHILD CARE/SCHOOL/HEALTH CARE PROVIDER

☐ **A) Child Care Up to Date**
Up to date through 6 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **B) Child Care Up to Date**
Up to date through 18 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **C) Child Care/Pre-school/Pre-K***
Up to date for Child Care/Pre-School/Pre-K for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **D) Complete for K–5th Grade**
Up to date for K–5th Grade for Colorado School Immunization Requirements — Update Signature _____ Date _____

* If age 4 years and fulfills Requirements for Pre-School & Kindergarten, check BOTH Boxes C and D.

Vaccine Preventable Disease Information

The information provided below is to ensure parents/guardians/students are informed about the risks of not vaccinating.

Diphtheria, tetanus, pertussis (DTaP, Tdap) - Unvaccinated children may be at increased risk of developing diphtheria, tetanus and/or pertussis if exposed to these diseases. Serious symptoms and effects of diphtheria include heart failure, paralysis, breathing problems, coma, and death. Serious symptoms and effects of tetanus include "locking" of the jaw, difficulty swallowing and breathing, seizures, painful tightening of muscles in the head and neck, and death. Serious symptoms and effects of pertussis (whooping cough) include severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures, brain damage, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/dtap.pdf and http://www.cdc.gov/vaccines/hcp/vis/vis-statements/tdap.pdf
Haemophilus influenza type b (Hib) – Unvaccinated children may be at increased risk of developing invasive Hib disease if exposed to this disease. Serious symptoms and effects include bacterial meningitis, pneumonia, severe swelling in the throat, permanent neurologic damage including blindness, deafness, and mental retardation, infections of the blood, joints, bones, and covering of the heart, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hib.pdf
Hepatitis B - Unvaccinated children may be at increased risk of developing hepatitis B if exposed to this disease. Serious symptoms and effects include jaundice, life-long liver problems such as liver damage, scarring, liver cancer, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.pdf
Inactivated poliovirus (IPV) – Unvaccinated children may be at increased risk of developing polio if exposed to this disease. Serious symptoms and effects include paralysis of muscles that control breathing, meningitis, permanent disability, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/ipv.pdf
Measles, mumps, rubella (MMR) - Unvaccinated children may be at increased risk of developing measles, mumps, and/or rubella if exposed to these diseases. Serious symptoms and effects of measles include pneumonia, seizures, brain damage, and death. Serious symptoms and effects of mumps include meningitis, painful swelling of the testicles or ovaries, sterility, deafness, and death. Serious symptoms and effects of rubella include rash, arthritis, and muscle or joint pain. If a pregnant woman gets rubella, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, and mental retardation. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mmr.pdf
Pneumococcal conjugate (PCV13) or polysaccharide (PPSV23) - Unvaccinated children may be at increased risk of developing pneumococcal disease if exposed to this disease. Serious symptoms and effects include pneumonia, lung infections, blood infections, meningitis and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/pcv13.pdf and http://www.cdc.gov/vaccines/hcp/vis/vis-statements/ppv.pdf
Varicella (chickenpox) – Unvaccinated children may be at increased risk of developing varicella if exposed to this disease. Serious symptoms and effects include severe skin infections, pneumonia, brain damage, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/varicella.pdf

Required Vaccines for School Entry - Place an "X" next to each vaccine you are declining.

	Diphtheria, tetanus, pertussis (DTaP)		Inactivated poliovirus (IPV)
	Tetanus, diptheria, pertussis (Tdap)		Measles, mumps, rubella (MMR)
	Haemophilus influenza type b (Hib)		Pneumococcal conjugate (PCV13) or polysaccharide (PPSV23)
	Hepatitis B		Varicella (chickenpox)

I am the parent/guardian of the above-named student or am the student himself/herself (emancipated or over 18 years of age) and am declining the vaccine(s) indicated above due to a religious or personal belief that is opposed to vaccines. The information I have provided on this form is complete and accurate.

- I may change my mind at any time and accept vaccination(s) for my child/myself in the future.
- I can review evidence-based vaccine information at www.colorado.gov/cdphe/immunization-education, or www.ImmunizeforGood.com for additional information on the benefits and risks of vaccines and the diseases they prevent.
- I can contact the Colorado Immunization Information System (CIIS) at www.ColoradoIIS.com or my health care provider to locate my child's/my immunization record.[3]

I acknowledge that I have read this document in its entirety.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

[3] Under Colorado law, you have the option to exclude your child's/your information from CIIS at any time. To opt out of CIIS, go to: www.colorado.gov/cdphe/ciis-opt-out-procedures. Please be advised you will be responsible for maintaining your child's/your immunization records to ensure school compliance.

Immunization

Certificate of Medical Exemption

cdphe.colorado.gov/immunization

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases, as established by Colorado Board of Health rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities, and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and Head Start programs.[1] The Certificate of Medical Exemption must be submitted once unless the student's information or school changes. Students with an immunization exemption on file may be kept out of a child care facility or school during a disease outbreak. The length of time will vary depending on the type of the disease and the circumstances of the outbreak.

Complete all required fields as indicated by an asterisk* below and obtain all required signatures. Incomplete forms will not be accepted. Completing all fields allows for us to process this exemption in a more expedited manner and to contact you should questions arise.

Student Information:

*Last Name:	*First Name:	Middle Name:
*Date of Birth:	Email:	*Sex: ☐ Female ☐ Male ☐ X

Parent/Guardian Completing This Form: ☐ Check if an emancipated student or student over 18 years old

If emancipated and under 18 years of age, please submit this exemption form and your emancipation documentation to cdphe.ciis@state.co.us.

*Last Name:	*First Name:	Middle Name:
Relationship to student: ☐ **Mother** ☐ Father ☐ Legal Guardian		

School/Licensed Child Care Facility Information:

*School Name/Licensed Child Care Facility:		
School District:		☐ Check if Not Applicable
*Address:		
*City:	*State:	*Zip Code:

Required Vaccines for School Entry

	*Check each vaccine declined:	*List medical contraindication(s)† for each vaccine declined:
☐	Hepatitis B (HepB)	
☐	Diphtheria, tetanus, pertussis (DTaP, Tdap)	
☐	Haemophilus influenzae type b (Hib)	
☐	Inactivated poliovirus (IPV)	
☐	Pneumococcal conjugate (PCV)	
☐	Measles, mumps, rubella (MMR)	
☐	Varicella (chickenpox)	

†Refer to the ACIP *General Best Practices Guidelines for Immunization: Guide to Contraindication and Precautions* for a list of acceptable contraindications and precautions: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

Statement of Medical Exemption

The physical condition of the above named student is such that vaccination would endanger their life or health or is medically contraindicated due to other medical conditions. The information I have provided on this form is complete and accurate.

***REQUIRED Print name, title, signature:** _____ *Date: _____

Physician (MD, DO), Advanced Practice Nurse (APN), or Physician Assistant (authorized pursuant to section 12-240-107 (6), C.R.S.)

***REQUIRED:** _____ ***REQUIRED:** Professional License Number: _____

(State/Territory)

DO NOT use this process or form for work-related vaccine exemptions or for vaccines that are not required for school entry in the state of Colorado. This includes vaccines for: COVID-19, hepatitis A (HepA), human papillomavirus (HPV), influenza (flu), meningococcal disease (MenACWY and MenB), and rotavirus (RV).

[1] Colorado Board of Health Rule 6 CCR 1009-2: : https://cdphe.colorado.gov/schoolrequiredvaccine

Under Colorado law, you have the option to exclude your child's/your information from the Colorado Immunization Information System (CIIS). To opt out of CIIS, go to: www.colorado.gov/cdphe/ciis-opt-out-procedures. Please be advised that you will be responsible for maintaining your child's/your immunization records to ensure school compliance.

Immunization

Certificate of Nonmedical Exemption

cdphe.colorado.gov/immunization

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases, as established by Colorado Board of Health Rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities, and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and Head Start programs. "Nonmedical exemption" means an immunization exemption based upon a religious belief whose teachings are opposed to immunizations or a personal belief that is opposed to immunizations. Prior to kindergarten, the Certificate of Nonmedical Exemption must be filed each time a student is due for vaccines according to the schedule developed by the Advisory Committee on Immunization Practices (ACIP).1,2 From kindergarten through 12th grade, the Certificate of Nonmedical Exemption must be filed every year during the student's school enrollment/registration process.1 Students with an immunization exemption on file may be kept out of a child care facility or school during a disease outbreak. The length of time will vary depending on the type of the disease and the circumstances of the outbreak.

Complete all required fields as indicated by an asterisk* below and obtain all required signatures. Incomplete forms will not be accepted. Completing all fields allows for us to process this exemption in a more expedited manner and to contact you should questions arise.

Student Information:

*Last Name:	*First Name:	Middle Name:
*Date of Birth:	Email:	*Sex: ☐ Female ☐ Male ☐ X

Parent/Guardian Completing This Form: ☐Check if an emancipated student or student over 18 years old

If emancipated and under 18 years of age, please submit this exemption form and your emancipation documentation to cdphe.ciis@state.co.us

*Last Name:	*First Name:	Middle Name:
Relationship to student: ☐ Mother ☐ Father ☐ Legal Guardian		

School/Licensed Child Care Facility Information:

*School Name/Licensed Child Care Facility:		
School District:		☐Check if Not Applicable
*Address:		
*City:	*State:	*Zip Code:

*Required Vaccines for School Entry - Place an "X" next to each vaccine for which you are claiming a nonmedical exemption.

	Diphtheria, tetanus, pertussis (DTaP)		Inactivated poliovirus (IPV)
	Tetanus, diphtheria, pertussis (Tdap)		Measles, mumps, rubella (MMR)
	Haemophilus influenzae type b (Hib)		Pneumococcal conjugate (PCV)
	Hepatitis B (HepB)		Varicella (chickenpox)

Statement of Exemption

I am the parent/guardian of the above-named student or am the student themself (emancipated or over 18 years of age) and am claiming a nonmedical exemption from the vaccine(s) indicated above. The information I have provided on this form is complete and accurate. I can review evidence-based vaccine information at www.colorado.gov/cdphe/immunization-education, https://childvaccineco.org/, and, www.ImmunizeForGood.com/ for additional information on the benefits and risks of vaccines and the diseases they prevent. I can contact the Colorado Immunization Information System (CIIS) at www.covaxrecords.org or my health care provider to locate my child's/my immunization record.[3]

***REQUIRED:** Signature:_____ Date: _____

Parent/Legal Guardian/Student (emancipated or over 18 years old)

REQUIRED Provider Signature Section:

***REQUIRED:** Print Name, Title, and Signature:_____ Date: _____

Physician (MD, DO), Advanced Practice Nurse (APN), Physician Assistant, Registered Nurse (RN) or Pharmacist (authorized pursuant to section 12-240-107 (6), C.R.S.)

***REQUIRED:** Colorado professional license number: _____

☐ Check if completed during the school's designated early registration period for the upcoming school year.

DO NOT use this process or form for work-related vaccine exemptions or for vaccines that are not required for school entry in the state of Colorado. This includes vaccines for: COVID-19, hepatitis A (HepA), human papillomavirus (HPV), influenza (flu), meningococcal disease (MenACWY and MenB), and rotavirus (RV).

[1] Colorado Board of Health Rule 6 CCR 1009-2: https://cdphe.colorado.gov/schoolrequiredvaccine

[2] Recommended Immunizations from Birth through 6 Years Old: www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf. Based on this schedule, a Certificate of Exemption would be submitted at 2 months, 4 months, 6 months, 12 months, and 18 months of age.

[3] Under Colorado law, you have the option to exclude your child's/your information from CIIS at any time. To opt out of CIIS, go to www.colorado.gov/cdphe/ciis-opt- out-procedures.‡

‡Please be advised you will be responsible for maintaining your child's/your immunization records to ensure school compliance.