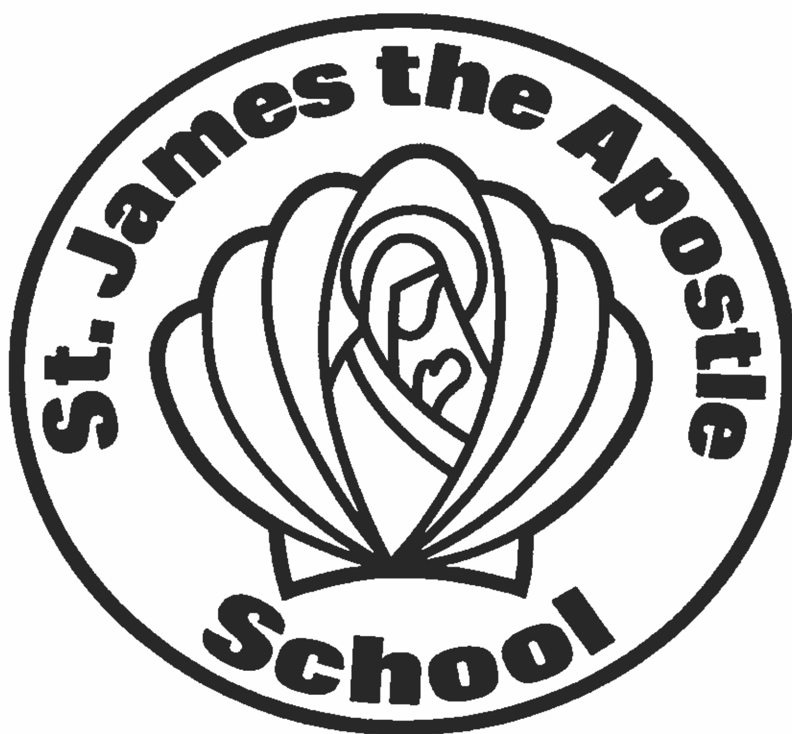
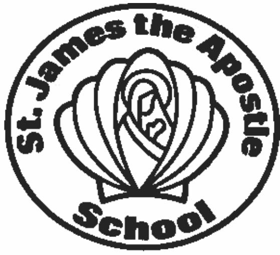
ST. JAMES THE APOSTLE SCHOOL

REGISTRATION PACKET

2019-2020



12 GLENEIDA AVENUE
CARMEL, NEW YORK 10512
PHONE: (845) 225-9365
FAX: (845) 228-2859
Email: frontoffice@stjamescarmel.org
Website: www.stjamescarmel.org



St. James the Apostle School

12 Gleneida Avenue
Carmel, New York 10512
Telephone: 845-225-9365
Fax: 845-228-2859

January 2019

Dear Parents,

We would like to take this opportunity to welcome you to our school family. For the past 65 years St. James the Apostle School has been nurturing countless numbers of children spiritually, academically and socially. It is our privilege to see them grow from the moment they timidly walk into PreK until the night of graduation when we see standing before us mature, confident and eager Catholic young men and women ready to take on the world!

It is our hope that this is the beginning of a real partnership in the Catholic educational future of your child. Together we will work to help your child discover a fruitful path filled with much success, multiple life lessons and a love for Jesus that will take your child through all of life's moments.

Please know that we are available to you and are grateful for your confidence in us. We look forward to many years together as we help your child to grow in their faith and love of learning.

Sincerely,

Valerie Crocco

Valerie Crocco, Principal
St. James the Apostle School

vc/jm

St. James the Apostle School
Tuition Rates – 2019-2020 School Year

Fees – Grades K-8

Registration Fee – Due at Registration	First Child	$	350.00
	Each Additional Child	$	200.00

Fees – Grades PreK – Full Day Program

Registration Fee – Due at Registration	First Child	$	350.00
	Each Additional Child	$	200.00

Fees – Grades PreK – Half Day Program

Registration Fee – Due at Registration	First Child	$	250.00
	Each Additional Child	$	150.00

PreK Half Day Tuition

3 Half Days	Monday, Wednesday, Friday	8:30am – 11:30am	$	2,500.00
5 Half Days	Monday through Friday	8:30am – 11:30am	$	3,000.00

PreK Full Day Tuition

3 Full Days	Monday, Wednesday, Friday	8:30am – 3:00pm	$	6,800.00
5 Full Days	Monday through Friday	8:30am – 3:00pm	$	7,300.00

Students Must Be Fully Toilet Trained

Grades Kindergarten through 8 – Tuition Rates

1 Child	$	6,800.00
2 Children	$	9,950.00
3 or more Children	$	12,050.00

Fundraising Requirements

Fundraising Requirement	$300.00 per year must be satisfied by May 1, 2020
Mandatory Bonanza Ticket	Cost $50.00 – Tickets distributed during November / December
Mandatory Card Party Ticket	Included in Registration Fee

Registration Fee – Non-Refundable

Tuition billed over a 10 months (August through May) – 1st payment due in August

ST. JAMES THE APOSTLE SCHOOL

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TELEPHONE: 845-225-9365
FAX: 845-228-2859

REQUIRED DOCUMENTS

STUDENT: ____

______________ BIRTH CERTIFICATE

______________ BAPTISMAL CERTIFICATE

______________ CURRENT IMMUNIZATION RECORD

______________ REGISTRATION FEE

ST. JAMES THE APOSTLE SCHOOL
12 Gleneida Avenue, Carmel, New York 10512, (845) 225-9365

Student Application

Please check one of the following:

________ Kindergarten through 8th Grade School Hours: 7:50am-2:40pm Grade Entering 2019-2020 ________

________ PreK – Full Day Program – 3 Full Days – 8:30am – 3:00pm – Monday, Wednesday, Friday

________ PreK – Full Day Program – 5 Full Days – 8:30am – 3:00pm – Monday through Friday

________ PreK – Half Day Program – 3 Half Days – 8:30am – 11:30am – Monday, Wednesday Friday

________ PreK – Half Day Program – 5 Half Days – 8:30am – 11:30am – Monday through Friday

PREK – STUDENTS ARE TO BE FULLY TOILET TRAINED. NO PULL-UPS OR DIAPERS

School District: ______________________________

Student's Information:

________________ ________________ ________________
Last Name First Name Middle Name

Date of Birth: ________________ Place of Birth: ________________

Address: ________________________________

City, State, Zip: ________________________________

Gender: ______ Religion: ________________ Primary Language Spoken At Home: ________________

Ethnicity: ________________ Parish: ________________

Sacrament	*Date*	*Church*	*Location*
Baptism			
Reconciliation			
Communion			
Confirmation			

Child Resides With: ________________________ Relationship: ________________

Responsible Party For Tuition: ________________________ Relationship: ________________

Father's Information: ***Please Circle:*** Single Married Separated Divorced Deceased

Last Name ____________ First Name ____________ Middle Name ____________

Address: ____________

City, State, Zip: ____________

Telephone: ____________ Cell Phone: ____________

Place of Birth: ____________ Religion: ____________

Home Email: ____________

Work Information:

Company: ____________

Address: ____________

City, State, Zip: ____________

Telephone: ____________ Occupation: ____________

Work Email: ____________

Mother's Information: ***Please Circle:*** Single Married Separated Divorced Deceased

Last Name ____________ First Name ____________ Maiden Name ____________

Address: ____________

City, State, Zip: ____________

Telephone: ____________ Cell Phone: ____________

Place of Birth: ____________ Religion: ____________

Home Email: ____________

Work Information:

Company: ____________

Address: ____________

City, State, Zip: ____________

Telephone: ____________ Occupation: ____________

Work Email: ____________

Custody of Child (if applicable)	***Guardianship of Child (if applicable)***
Custodial Parent ____________________	Guardian ____________________
Relationship ____________________	Relationship ____________________
Documentation ____________________	Documentation ____________________
Date Provided____________________	Date Provided____________________

Student's Education: Previous Schools Attended

Name of School	*Address*	*Grade*	*Date Attended*

Child has been evaluated by the District Committee on Special Education ________ Yes ________ No

Child has been evaluated by a Private Psychological of Educational Agency ________ Yes ________ No

If answer to either or both statements above is YES, applicant must complete the following:

Type of Evaluation	*Date*	*Name of Agency*	*Contact Name and Phone*
Educational			
Psychological			
Speech			
Other ____________			

If child has been seen by the Public District Committee on Special Education, applicant must complete the following:

1. Was an IEP generated? ________ Yes ________ No Copy Submitted (Date) ____________
2. Child has a Section 504 Accommodation Plan ________ Yes ________ No Copy Submitted (Date) ____________

District Name and Number	*Date of Most Recent IEP*	*Date of Last Psychological Evaluation*	*Classification and Recommended Placement*

Emergency Contact (If parent cannot be reached):

1. ______________________________ *Relationship*____________________

Home Phone: ____________________ *Cell Phone:*____________________

2.. ______________________________ *Relationship*____________________

Home Phone: ____________________ *Cell Phone:*____________________

Child's Physician:

Name: ______________________________ ***Phone:*** ______________

Is there any medical information, including allergies, we should be aware of?

____

____

____

____

____

____

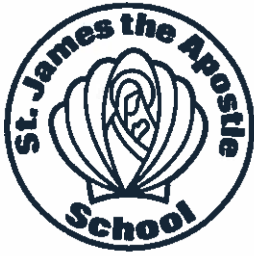
The student fee, which must accompany this form, is non-refundable unless the child is not accepted. Registration is not complete until we receive a birth certificate, baptismal certificate, and immunization records, for the above student and have been reviewed by the school. Information given which is inaccurate, incomplete, or misleading may be grounds for refusing or canceling registration.

Tuition is an annual fee, but may be paid over ten months. I accept the obligation to pay the tuition by the 5th of each month. I also accept the obligation to participate in fund raising or to make a donation to the school, according to annual guidelines, or have the required amount added to my tuition charges. If I am a parishioner of St. James, I agree that my children and I are expected to worship at Sunday Mass here and to contribute at least $15.00 each week in the regular Sunday envelopes provided by the rectory (applies to Kindergarten through 8th grade only).

I affirm that the above information is true to the best of my knowledge. I understand that failure to provide the required documentation stops the application process. Furthermore, should my child be accepted/admitted under false, incomplete or negligent information, my child will be dismissed from the school. I also agree that should my child be accepted/admitted, my child and I will be bound by the terms and conditions of the school's parent/student handbook including those provisions referencing inoculations. Final acceptance is also dependent on all fees being paid in full to previous school.

Date: ______________

Parent/Guardian's Signature: ______________________________



St. James the Apostle School

12 Gleneida Avenue
Carmel, New York 10512
Telephone: 845-225-9365
Fax: 845-228-2859

January 2019

Dear Parents,

St. James the Apostle will once again offer an Afterschool Program for our PreK Full Day through 8th Grade. The program is not available for students in the PreK Half Day Session. The program begins immediately after dismissal and ends promptly at 6:00pm. Please note that a late fee of $25.00 will be assessed if the child is picked up after 6:00pm.

The cost is as follows:

$10.00 per hour	Families with 1 child
$15.00 per hour per family	Families with 2 or more children

Children may only be picked up by a parent unless a written note is presented stating otherwise. Please complete the attached registration form if you plan on using the program and return to the school office.

Please be advised that we reserve the right to cancel afterschool during inclement weather. All parents will be notified immediately. If you have any questions, please feel free to contact Mrs. Joanne Mascia at (845) 225-9365 or by email at joanne.mascia@stjamescarmel.org.

Sincerely,

Valerie Crocco

Valerie Crocco, Principal
St. James the Apostle School

vc/jmm

St. James the Apostle School

12 Gleneida Avenue
Carmel, New York 10512
(845) 225-9365

Afterschool Registration & Emergency Contact Form

Student Information

Last Name: ______________________ First :______________________

Address: ____

City, State, Zip Code: ______________________________________

Home Phone:______________________ Grade Entering (School Year 19-20) ________

Mother/Guardian Information

Last Name: ______________________ First :______________________

Work Phone: ______________________ Cell Phone:______________________

Father/Guardian Information

Last Name: ______________________ First :______________________

Work Phone: ______________________ Cell Phone:______________________

Emergency Contacts

Please list in order of who to call in case of an emergency if parent cannot be reached

1. ______________________________ Phone: ______________________

2.______________________________ Phone: ______________________

Email Address: ____

Regular Permanent Basis: **Please Check Off Days Needed**

Regular Permanent Basis means you have requested that your child(ren) be placed in afterschool on the days checked below unless a note is sent in on those particular days requesting otherwise

______ Monday ______ Tuesday ______Wednesday ________Thursday _______ Friday

______As Needed Only Please list any food allergies ______________________________

Please be advised that we reserve the right to cancel afterschool during inclement weather. All parents will be notified immediately.

Parent Signature: ____

ST. JAMES THE APOSTLE SCHOOL

12 GLENEIDA AVENUE
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TELEPHONE: 845-225-9365
FAX: 845-228-2859

Dear Parents / Guardian:

The State of New York has recently (May 2018) made changes to the screening and Health examination requirements for students entering school in September 2018.

To insure that your child's health is being monitored, children in grades Kindergarten, 1st, 3rd, 5th, 7th and new entrants have a physical examination. Please note the changes to the grade levels.

Your family physician is best informed about your child's health; therefore, we encourage you to have him/her perform this examination. If you do not have a family physician or prefer the examination to be done in school, we will arrange to have your child examined by our school physician.

If your child is in any of the grades listed above, please complete the form below with your preference, and return it to the school nurse by September 15.

If you elect to have the physical examination done by your child's physician, please have the examination completed and return the attached form by November 1st. Please don't hesitate to contact the school nurse with questions at extension 121.

Sincerely,

Valerie Crocco

Valerie Crocco, Principal
St. James the Apostle School

PARENT'S PREFERENCE FOR CHILD'S PHYSICAL EXAMINATION

Name of Child: ____

Grade: __________ Date of Birth: _______________ Teacher: ____________________

I want my child's physical examination done by: (check one)

______ School Physician

______ Child's Physician Name of Physician: ______________________________

Date of Appointment, if scheduled: ________________________

Parent's Signature: ______________________________ Date: ____________

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No	☐ Medication/Treatment Order Attached	☐ Anaphylaxis Care Plan Attached
☐ Yes, indicate type	☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental	
Asthma ☐ No	☐ Medication/Treatment Order Attached	☐ Asthma Care Plan Attached
☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ____________	
Seizures ☐ No	☐ Medication/Treatment Order Attached	☐ Seizure Care Plan Attached
☐ Yes, indicate type	☐ Type: ____________	Date of last seizure: ________
Diabetes ☐ No	☐ Medication/Treatment Order Attached	☐ Diabetes Medical Mgmt. Plan Attached
☐ Yes, indicate type	☐ Type 1 ☐ Type 2 ☐ HbA1c results: ________	Date Drawn: ________

Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI__________kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
Sickle Cell Screen/PRN	☐	☐		☐ Concussion – Last Occurrence: ____________
Lead Level Required Grades Pre-K & K			Date	☐ Mental Health: ____________
☐ Test Done ☐ Lead Elevated ≥10 µg/dL				☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list)	ICD-10 Code
____________	________
____________	________
____________	________

☐ Additional Information Attached

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		**Trunk Rotation Angle:**		
Recommendations:				

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity without restrictions including Physical Education and Athletics.**

☐ **Restrictions/Adaptations** — Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** — Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** — Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports

Student is at Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations: Use additional space below to explain**

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: ____________________

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

ST. JAMES THE APOSTLE SCHOOL

12 GLENEIDA AVENUE
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TELEPHONE: 845-225-9365
FAX: 845-228-2859

January 2019

Dear Parents,

As a part of your child's requirements for school, a physical examination has been required for students in Kindergarten, 1st, 3rd, 5th and 7th grade. A law was recently enacted that expands health screenings to include the dental health of students in New York State.

After September 1, 2008, when we require that your child have a physical examination, we will be requesting a dental certificate as well. There is a sample certificate available for you to take to your child's dentist and once it is completed, it should be returned to the School Nurse as it will be filed in your child's Cumulative Health Record.

Thank you for your cooperation in this new health endeavor. Our students benefit when we work together to promote the health and achievement of all students.

Please call the School Nurse at (845) 225-9365 ext. 121 if you have any questions or concerns.

Sincerely,

Valerie Crocco

Valerie Crocco, Principal
St. James the Apostle School

vc/jm

SAMPLE

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / (Month Day Year)

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment ? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature ______________________________ Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of ______________________ _______ on__________ (date of assessment)
The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address (please print or stamp)	**Dentist's/Dental Hygienist's Signature**

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):______________________________

II. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

St. James the Apostle School

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January 2019

Dear Parent,

New York State Public Health Law states that a child cannot be permitted to attend school without documented evidence of certain immunizations.

We look forward to welcoming your child to Saint James and remind you to be sure that their immunizations are up to date for school.

Documented evidence means that each immunization date must be recorded and signed by a doctor or bear his signature stamp or the Health Department stamp. I include a copy of the immunization requirements for school.

Please bring or mail this information to St. James the Apostle School as soon as possible before school begins.

Thank you for your cooperation.

Sincerely,

Valerie Crocco

Valerie Crocco, Principal
St. James the Apostle School

vc/jm

2018-19 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). For grades pre-k through 10, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: intervals between doses of polio vaccine DO NOT need to be reviewed for grades 5, 11 and 12.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 11 and 12. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule.

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3 and 4	Grade 5	Grades 6, 7, 8, 9 and 10	Grades 11 and 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses** or **4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older		**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)[3]	**Not applicable**			**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses** or **3 doses** if the 3rd dose was received at 4 years or older	**3 doses**	**4 doses** or **3 doses** if the 3rd dose was received at 4 years or older	**3 doses**
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**			
Hepatitis B vaccine[6]	**3 doses**	**3 doses** or **2 doses** of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years			
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**	**1 dose**	**2 doses**	**1 dose**
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**			**Grades 7, 8 and 9: 1 dose**	**Grade 12: 2 doses** or **1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**			
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**			

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday.
   b. If the fourth dose of DTaP was administered at 4 years or older, the fifth (booster) dose of DTaP vaccine is not required.
   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older. A Tdap vaccine (or incorrectly administered DTaP vaccine) received at 7 years or older will meet the 6th grade Tdap requirement.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap. A dose received at 7 years or older will meet this requirement.
   b. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. Intervals between the doses of polio vaccine do not need to be reviewed for grades 5, 11 and 12 in the 2018-19 school year.
   e. If both OPV and IPV were administered as part of a series, the total number of doses and intervals between doses is the same as that recommended for the U.S. IPV schedule. If only OPV was administered, and all doses were given before age 4 years, 1 dose of IPV should be given at 4 years or older and at least 6 months after the last OPV dose.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten and grades 11 and 12. Two doses are required for grades kindergarten through 10.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks.
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine. (Minimum age: 6 weeks)
   a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7, 8 and 9.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. Unvaccinated children ages 7 through 11 months of age are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months or older, no further doses are required.
   e. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

St. James the Apostle School

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Student photos are used on our Facebook Page, News Articles and School Webstie

Please sign and complete the permission slip.

___ St. James the Apostle School **has permission** to use photos of my child(ren).

___ **Please DO NOT use my child(ren) photos.**

Student: ______________________ Grade: __________

Student: ______________________ Grade: __________

Student: ______________________ Grade: __________

Student: ______________________ Grade: __________

Parent's Signature: ______________________ Date:__________