HEALTH REQUIREMENTS FOR **KINDERGARTEN** SCHOOL ENTRY

Physical assessments must be done within a year of the opening date of the school year.

The blue health form must be turned into the school nurse for review before the first day of school.

Physicals must be done by a M.D., A.P.R.N., or P.A.

Physicals must include:

- Height
- Weight
- Blood Pressure
- Hemoglobin
- Speech
- Urine (protein, glucose) screening – highly recommended, but not required
- Dental Screening
- Postural Screening
- Vision Screening
- Hearing Screening
- Chronic Disease Assessment

IMMUNIZATION REQUIREMENTS

DPT – 4 doses are required and at least one of these doses must fall on or after the child's fourth birthday.

POLIO (OPV/IPV) – 3 doses are required and at least one of these must fall on or after the child's fourth birthday.

HIB – 1st dose on or after first birthday for children less than 5 years old.

MMR – 2 doses are required at time of initial entry. The first dose must be 12 months of age or older.

HEPATITIS B Vaccine – a series of 3 doses are required for students / last dose on or after 24 weeks of age.

HEPATITIS A Vaccine – 2 doses given 6 months apart, 1st dose on or after 1st birthday.

VARICELLA – 2 doses separated by at least 3 months, 1st dose on or after 1st birthday or verification of disease.

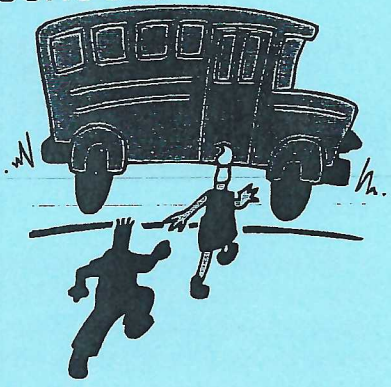
Pneumoccoccal – 1 dose on or after 1st birthday for children less than 5 years old.

PARENTS / GUARDIANS – Please make a copy of the completed health assessment for your own personal records. This information may be needed for child daycare providers, sports, scouts, etc. Send completed form to school before the first day of school.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

IMMUNIZATION REQUIREMENTS FOR ENROLLED STUDENTS IN CONNECTICUT SCHOOLS



PRESCHOOL

DTaP:	4 doses (by 18 months for programs with children 18 months of age)
Polio:	3 doses (by 18 months for programs with children 18 months of age)
MMR:	1 dose on or after 1st birthday
Hep B:	3 doses, last one on or after 24 weeks of age
Varicella:	1 dose on or after 1st birthday or verification of disease
Hib:	1 dose on or after 1st birthday
Pneumococcal:	1 dose on or after 1st birthday
Influenza:	1 dose administered each year between August 1st-December 31st (2 doses separated by at least 28 days required for those receiving flu for the first time)
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday

KINDERGARTEN

DTaP:	At least 4 doses. The last dose must be given on or after 4th birthday
Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Hep B:	3 doses, last dose on or after 24 weeks of age
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease
Hib:	1 dose on or after 1st birthday for children less than 5 years old
Pneumococcal:	1 dose on or after 1st birthday for children less than 5 years old
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday

GRADES 1-6

DTaP/Td:	At least 4 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses.
Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Hep B:	3 doses, last dose on or after 24 weeks of age
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday

GRADE 7

Tdap/Td:	1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap
Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Meningococcal:	1 dose
Hep B:	3 doses, last dose on or after 24 weeks of age
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday

Revised 1/3//2019

GRADES 8-12	Tdap/Td:	1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap
	Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
	MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
	Meningococcal:	1 dose
	Hep B:	3 doses, last dose on or after 24 weeks of age
	Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease

- DTaP vaccine is not administered on or after the 7th birthday.
- Tdap can be given in lieu of Td vaccine for children 7 years and older unless contraindicated.
- Hib is required for all Pre-K and K students less than 5 years of age.
- Pneumococcal Conjugate is required for all Pre-K and K students less than 5 years of age.
- Hep A requirement for school year 2019-2020 applies to all Pre-K through 7th graders born 1/1/07 or later.
- Hep B requirement for school year 2019-2020 applies to all students in grades K-12. Spacing intervals for a valid Hep B series: at least 4 weeks between doses 1 and 2; 8 weeks between doses 2 and 3; at least 16 weeks between doses 1 and 3; dose 3 must be administered at 24 weeks of age or later.
- Second MMR for school year 2019-2020 applies to all students in grades K-12.
- Meningococcal Conjugate requirement for school year 2019-20 applies to all students in grades 7-12
- Tdap requirement for school year 2019-2020 applies to all students in grades 7-12
- If two live virus vaccines (MMR, Varicella, MMRV, Intra-nasal Influenza) are not administered on the same day, they must be separated by at least 28 days (there is no 4 day grace period for live virus vaccines). If they are not separated by at least 28 days, the vaccine administered second must be repeated.
- Lab confirmation of immunity is **only** acceptable for Hep A, Hep B, Measles, Mumps, Rubella, and Varicella.
- **VERIFICATION OF VARICELLA DISEASE:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

For the full legal requirements for school entry visit:
https://portal.ct.gov/DPH/Immunizations/Immunization--Laws-and-Regulations

If you are unsure if a child is in compliance, please call the Immunization Program at (860) 509-7929.

New Entrant Definition:

*New entrants are any students who are new to the school district, including **all** preschoolers and all students coming in from Connecticut private, parochial and charter schools located in the same or another community. **All pre-schoolers, as well as all students entering kindergarten**, including those repeating kindergarten, and those moving from any public or private pre-school program, even in the same school district, **are considered new entrants**. The one exception is students returning from private approved special education placements–they are not considered new entrants.

Commonly Administered Vaccines:

Vaccine:	Brand Name:	Vaccine:	Brand Name:
DTaP-IPV-Hib	Pentacel	MMRV	ProQuad
DTaP-HIB	TriHibit	PCV7	Prevnar
HIB-Hep B	Comvax	PCV13	Prevnar 13
DTaP-IPV-Hep B	Pediarix	DTaP-IPV	Kinrix, Quadracel
Hepatitis A	Havrix, Vaqta	Influenza	Fluzone, FluMist, Fluviron, Fluarix, FluLaval Flucelvax, Afluria

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 ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
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**			***Auditory Screening**			History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	Date
Type:	Right	Left	Type:	Right	Left		
With glasses	20/	20/		❑ Pass ❑ Fail	❑ Pass ❑ Fail	***HCT/HGB:**	
Without glasses	20/	20/				***Speech** (school entry only)	
❑ Referral made			❑ Referral made			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. 4/2012

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 for 7th grade entry	
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	*	*			PK and K (born 1/1/2007 or later)	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			2 doses required for K & 7th grade as of 8/1/2011	
PCV	*				PK and K (born 1/1/2007 or later)	
Meningococcal	*				Required for 7th grade entry	
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** ____

Recertify Date _____ Recertify Date _____ Recertify Date _____

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN

- DTaP: At least 4 doses. The last dose must be given on or after 4th birthday.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 day apart – 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after 1st birthday (Children 5 years and older do not need proof of Hib vaccination).
- Pneumococcal: 1 dose on or after 1st birthday (born 1/1/2007 or later and less than 5 years old).
- Hep A: 2 doses given six months apart-1st dose on or after 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students enrolled before August 1, 2011, 1 dose given on or after 1st birthday; for students enrolled on or after August 1, 2011 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 1-6

- DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 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. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses – the last dose on or after 24 weeks of age.
- Varicella: 1 dose on or after the 1st birthday or verification of disease*.

GRADE 7

- Tdap/Td: 1 dose of Tdap for students 11 yrs. or older enrolled in 7th grade who completed their primary DTaP series; For those students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are needed, one of which **must** be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart – 1st dose on or after the 1st birthday.
- Meningococcal: one dose for students enrolled in 7th grade.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 8-12

- Td: At least 3 doses. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine one of which should be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart or verification of disease*.

* **Verification of disease:** Confirmation in writing by a 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 nation-wide 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

Parent to complete this questionnaire

New Milford Public Schools
Pupil's Health History

Date _____

Child's Name (include "nickname")_____ Sex ____ Birth date _____

Home Address _____Mailing address (if different from home address_____

Parent/Guardian Names:	Mailing address if different from your home address	Home phone #	Work phone #	Cell #
Mother's Name:				
Father's Name:				
Guardian name – if applicable				
Step parent name –if applicable				

Child lives with: Mother & Father / Mother / Father / Mother or Father & Step-parent / Guardian

Does your child have health insurance? Please circle: YES NO

Child's primary Physician: _____ Phone #_____ Address_____

Dentist _____ Phone # _____ Address_____

Child's Health History *If any of these conditions exist, please describe (include symptoms, dates, treatments, surgical procedures, Medications used, limitations, etc). Use reverse side if needed.*

Life Threatening Allergies (only those that require Epipen/ Benadryl) - include date of most recent reaction & what happened & treatment:

- **Food**
- **Drug**
- **Insect**

Asthma / triggers / early symptoms/ medications:

Bladder / Bowel:

Cardiac:

Diabetes:

Ears (i.e. tubes in / out:):

Environmental Allergies:

Food Intolerance / Sensitivity:

Kidney / Urinary:

Current Medications if applicable:

Musculoskeletal:

Neurological (Epilepsy/ Seizures):

Skin (i.e. Birthmarks, Eczema, Mongolian spots):

Surgical Procedures:

Vision: Does child wear glasses? (circle one) Distance only / Reading only / At all times

Examining physician: **Date of last exam:** **Diagnosis:**

Other Concerns (i.e. developmental, speech):

School Nurse Resource List of Area Clinics

Minute Clinic: located at CVS Pharmacy New Milford

- Hours: Mon –Fri: 8:30am-7:30pm Sat: 9am-5:30pm, Sun: 10am-5:30pm
  Lunch: M-F 2-3pm, Sa/Su 11-1:30
- www.minuteclinic.com 1-866-389-ASAP
- Physicals, Sports physicals, minor illness exams
- Accept most insurances

Physicians One Urgent Care of Connecticut: 31 Old Route 7, Brookfield ,Ct 06804

- www.ucofconnecticut.com 203-885-0808
- Open 7 days a week-365 days a year
- Accepts many insurances

Danbury Community Healthcare Resources

1. Americares
   76 West Street, Danbury
   Phone: 203-748-6188
   Free Clinic

2. Community Health Center
   8 Delay Street, Danbury
   Phone: 203-797-8330
   Insurance/HUSKY/Sliding Scale

3. Doctor's Express: Urgent Care, Physicals, Lab and X-ray onsite
   2 Main Street, Danbury
   Phone: 203-826-2140
   Most insurances including HUSKY accepted.

4. Greater Danbury Community Health Center
   57 North Street, Danbury
   203-743-0100
   Insurance/HUSKY/Sliding Scale

5. Optimum Medical
   205 Main Street, Danbury
   Phone: 203-794-9000
   Insurance/HUSKY

6. **Samaritan Health Center**
   13 Rose Street, Danbury
   Phone: 203-791-2794
   Free Clinic for children up to 18 years old

7. Seifert and Ford Community Health Center
   70 Main Street, Danbury
   Adult Clinic: 203-791-5030
   Dental Clinic: 203-791-5010
   Pediatric Clinic: 203-791-5020

New Milford Public Schools
Tuberculosis (TB) Risk Assessment Questionnaire

Name_____ **Grade**

Parents of students new to New Milford Public Schools are required to complete TB Risk Assessment Questionnaire prior to school entry. Parents of students in Kindergarten, Grade 6 and Grade 9 should fill out TB Risk Assessment Questionnaire to be reviewed by student's Physician when student is seen for mandated physical exam.

Please answer the following questions yes or no:

1. **Was your child born outside the US?** _____
   If born in any of the countries in the attached list, a TST* or IGRA* should be performed. (Note IGRA's are not recommended for children <5 years old)

2. **Has your child traveled outside the US?** _____
   If the child traveled to any of the listed countries, stayed for > 1 week and interacted with the local population, including local family or friends, then a TST or IGRA should be performed. For most children, testing, after evaluation for possible signs and symptoms of TB disease or exposure to a person with contagious pulmonary TB, can take place 8-10 weeks after return to the United States.

3. **Has your child been exposed to anyone with TB disease?** _____
   If yes, determine whether the person had TB disease of latent TB infection, when the exposure occurred and what the nature of the contact was. If it is confirmed that the person had known or suspected TB disease, a TST or IGRA should be performed.

4. **Does your child have close contact with someone with a positive TB skin test?**_____
   If yes, see previous question for follow-up information needed

5. **Does your child live with anyone who has been in jail or prison, a shelter, who injects illegal drugs, or has HIV?** _____
   If yes, then a TST or IGRA should be performed.

6. **Has your child eaten unpasteurized cheese from Mexico or Central America since their last TST or IGRA?**_____
   If yes, a TST or IGRA should be performed.

Parent Signature_____ Date_____

*TST- Tuberculin Skin Test
*IGRA-Interferon-gamma release assay (blood test)
Any student who is identified as having a positive reaction to TST or IGRA shall present a letter from the physician stating that a chest x-ray has been administered and student is free from active Tuberculosis prior to school entry.
TB Risk Assessment Questionnaire submitted to school nurse.

4/13 LH

Appendix B: List of High Risk[1] Tuberculosis Countries

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
China, Hong Kong Special Administrative Region
China, Macao Special Administrative Region
Colombia
Comoros
Congo
Cook Islands
Côte d'Ivoire
Croatia
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
The former Yugoslav Republic of Macedonia
Timor-Leste
Togo
Tonga
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

[1] Greater than 20/100,000 population
Estimates can be found at http://apps.who.int/ghodata/?vid=500