REQUIRED VACCINES FOR SCHOOL/DAYCARE ATTENDANCE

NAME	NUMBER OF DOSES
Diphtheria/tetanus/pertussis	5 doses (4 if the 4th dose was received after the 4th birthday; A booster dose of Tdap vaccine must be given at 11 or 12 years of age beginning fall 2010)
Polio	4 doses (3 if the 3rd dose was received on or after the 4th birthday)
Measles/Mumps/Rubella	2 doses Measles, 1 dose of Mumps, and 1 dose of Rubella
Hib	4 doses up to age 5
PCV	4 doses (see catchup schedule for children who have fallen behind)
Varicella	1 dose (2 doses separated by at least 28 days for persons 13 years of age or older beginning the vaccination series)

Grade Requirements Varicella Vaccine

2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
K(5) – 1st	K(5) – 2nd	K(5) – 3rd	K(5) – 4th	K(5) – 5th	K(5) – 6th	K(5) – 7th	K(5) – 8th	K(5) – 9th	K(5) – 10th	K(5) – 11th	K(5) – 12th

Grade Requirements for Tdap Vaccine

2010	2011	2012	2013	2014	2015	2016
6th	7th	8th	9th	10th	11th	12th

STATE OF ALABAMA
TEMPORARY MEDICAL EXEMPTION

EXPIRATION DATE REQUIRED
(Date next vaccine is due)

_____
Month Day Year

This section of the Alabama Certificate of Immunization is to be used when vaccines are deferred for a short period of time for medical reasons. The expiration date on the other side of this certificate applies to vaccines not covered by this temporary exemption. The expiration date in this section applies to temporarily deferred vaccines only. A temporary medical exemption must be signed by a physician.

The administration of _____ vaccine(s) is/are medically contraindicated at this time.

AUTHORIZED MEDICAL SIGNATURE: _____

NAME OF CLINIC: _____

TELEPHONE NUMBER: _____

DATE: _____

STATE OF ALABAMA
PERMANENT MEDICAL EXEMPTION

This section of the Alabama Certificate of Immunization is to be used when vaccines are contraindicated for medical reasons. The expiration date on the front of the certificate applies to vaccines not covered by this permanent medical exemption. This exemption must be signed by a physician.

The administration of _____ vaccine(s) is/are medically contraindicated at this time.

AUTHORIZED MEDICAL SIGNATURE: _____

NAME OF CLINIC: _____

TELEPHONE NUMBER: _____

DATE: _____