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ATTENTION PARENT – YOUR CHILD IS NOT ELIGIBLE TO BE ENROLLED IN 7TH GRADE!!

If you are receiving this letter, your student needs the Tdap immunization in order to attend 7th grade. **Before February 1, 2017**, you must provide your child's school with official documentation of your child's Tdap immunization. **Your child will not be allowed to check out books, receive a schedule or attend school in August 2017 without official documentation of the Tdap immunization provided to your child's school.**

To be ready for 7th grade, **please follow the steps below now**:

1. Call for an immunization appointment NOW. Do not wait! Appointments and clinics fill up early and your child will not be allowed to start 7th grade without the Tdap or any other required immunization.
2. Take your child's yellow immunization form, or this letter, to the physician or clinic for documentation of the Tdap immunization.
3. Provide official documentation of the immunization to the school site ***before February 1, 2017.***

Beginning January 1, 2016, under California State law SB 277, exemptions based on personal beliefs will no longer be an option for the vaccines that are required for school entry. For further immunization information, please visit the 'Shots for School' website at www.shotsforschool.org.

For information regarding local immunization clinics for the required Tdap booster vaccine, you may call San Bernardino Public Health Department at **1-800-722-4794.**

*Thank you for your **immediate response** in obtaining this required immunization!*

Sincerely,

Charlene Dean, RN

Charlene Dean, R.N., B.S.N.
Health Services Coordinator

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*Documentation on **your student's official immunization record is preferred**. Please take your child's yellow immunization record to the physician's office for documentation of the Tdap vaccine. The area below may be used for documentation by the **PHYSICIAN OR CLINIC**, if your yellow immunization card is not available.*

Student Name*:	**Date of Birth*:**			
IMMUNIZATION	**DOSE**	**MONTH***	**DAY***	**YEAR***
Tdap Booster	1			
Additional Immunizations (If needed, include name)				

Name of physician (or stamp)*: ______________________ Date*: __________

Address of physician (or stamp)*: ______________________

Signature of physician*: ______________________ Phone Number*: __________

***If this form is being used as official documentation, the pertinent information is required by the attending physician.**