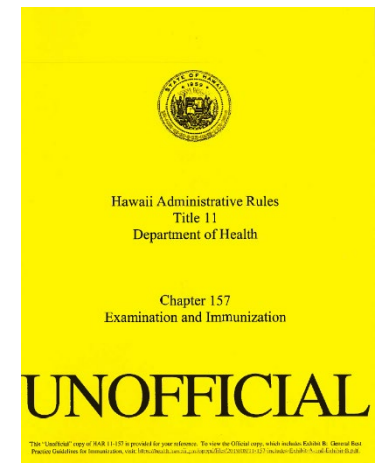


Immunization and Examination Requirements for Childcare and School Attendance 2020-2021 School Year and beyond

Hawaii Department of Health
Immunization Branch

Background

- Hawaii Administrative Rules (HAR), Title 11, Chapter 157 establish immunization and examination requirements for child care facility, school, and post-secondary school attendance in Hawaii.
- Last amended in 2001
- Updates to HAR 11-157: **effective July 1, 2020** for all Hawaii students entering:
 - Childcare/Preschool
 - Kindergarten through Grade 12
 - 7th grade
 - Colleges and universities



Health Examination Requirements

- Physical examination required:
 - First attendance at child care facility or school in Hawaii
 - All students entering 7th grade
- Physical examination shall be documented on a form/format approved by Department of Health
- Must be within 12 months before date of first attendance
- Must be signed by practitioner performing examination
- Valid physical examination may be used for transfer to other child care facilities or schools in Hawaii

Who may perform Physical Examination?

- Practitioner:
 - Physician
 - Advanced practice registered nurse
 - Physician assistant
- Must be licensed to practice in any state or territory of U.S.

Required Immunizations for Child Care Facility and School Attendance

- Refer to Immunization Requirements Summary
 - Required immunizations
 - Number of doses
 - Minimum ages and intervals between doses
 - Exceptions to Immunization Requirements



Immunization Requirements Summary

- All immunizations must meet minimum age and minimum interval requirements
- Grace period: vaccine doses administered ≤ 4 days before the minimum age or interval are considered valid unless otherwise specified
 - The 4-day grace period does NOT apply to the interval between two different live virus vaccines (e.g., MMR and varicella)
 - If not administered on the same day, a minimum interval of 4 weeks is required between two doses of different live virus vaccines
- The use of trade names is for identification purposes only and does not imply endorsement by the Hawaii Department of Health
- For additional information, see General Best Practice Guidelines for Immunization: https://health.hawaii.gov/docd/files/2019/08/HAB11-157_EXHIBIT_B.pdf
- If you have any questions, please call the Hawaii Department of Health Immunization Branch at (808) 586-8300

<https://health.hawaii.gov/docd/files/2019/10/Immunization-Requirements-Summary.pdf>

Required immunizations for **Child-Care Facility** attendance

- For children younger than 2 years, number of required doses depends on child's age
- Refer to Immunization Requirements Summary, Table 1




TABLE 1: REQUIRED IMMUNIZATIONS – CHILD CARE CENTER/PRESCHOOL*

BY THIS AGE	STUDENTS ARE REQUIRED TO HAVE							
	DTAP (Diphtheria, Tetanus, Pertussis)	POLIO	Hib** (<i>Haemophilus influenzae</i> type B)	PCV** (Pneumococcal Conjugate Vaccine)	HEPATITIS B	HEPATITIS A	MMR (Measles, Mumps, Rubella)	VARICELLA (Chickenpox)
3 MONTHS	1 dose	1 dose	1 dose	1 dose	2 doses	Not required at this age	Not required at this age	Not required at this age
5 MONTHS	2 doses	2 doses	2 doses	2 doses	2 doses	Not required at this age	Not required at this age	Not required at this age
7 MONTHS	3 doses	2 doses	2 - 3 doses ¹	3 doses	2 doses	Not required at this age	Not required at this age	Not required at this age
16 MONTHS	3 doses	2 doses	3 - 4 doses ²	4 doses ³	2 doses	Not required at this age	1 dose	1 dose
19 MONTHS	4 doses	3 doses	3 - 4 doses ²	4 doses ³	3 doses	1 dose	1 dose	1 dose
24 MONTHS	4 doses	3 doses	3 - 4 doses ²	4 doses ³	3 doses	2 doses	1 dose	1 dose

*SEE TABLE 6: EXCEPTIONS TO IMMUNIZATION REQUIREMENTS

**FOR INFORMATION ON CHILDREN WHO START THE Hib OR PCV SERIES AT AGE 7 MONTHS OR OLDER, SEE TABLE 5A AND 5B

¹If all PedvaxHIB® (Merck) administered, 2 doses are required
 If ActHIB® (sanofi), Pentacel® (sanofi), or Hiberix® (GSK) administered, 3 doses are required
 If both PedvaxHIB® and either ActHIB®, Pentacel®, or Hiberix® administered, or if product type is UNKNOWN or not listed here, 3 doses are required

²If all PedvaxHIB® (Merck) administered at the routinely recommended ages (2, 4, 12-15 months), 3 doses are required.
 If ActHIB® (sanofi), Pentacel® (sanofi), or Hiberix® (GSK) administered at the routinely recommended ages (2, 4, 6, 12-15 months), 4 doses are required.
 If both PedvaxHIB® and either ActHIB®, Pentacel®, or Hiberix® administered at the routinely recommended ages (2, 4, 6, 12-15 months), or if product type is UNKNOWN or not listed here, 4 doses are required.
 The number of doses required for children who did not receive Hib at the routinely recommended ages depends on the child's age at the time of administration of each dose and the vaccine product. Refer to the CDC's Catch-up Immunization Schedule at: <https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf>

³If administered at the routinely recommended ages (2, 4, 6, 12-15 months), 4 doses of PCV are required.
 The number of doses required for children who did not receive PCV at the routinely recommended ages depends on the child's age at the time of administration of each dose. Refer to the CDC's Catch-up Immunization Schedule at: <https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf>

Required immunizations for **Child-Care Facility** attendance

Children aged 2 years & older

<u>Vaccine</u>	<u>Number of Doses</u>
• DTaP	4
• Hib	3-4
• Hepatitis A	2
• Hepatitis B	3
• MMR	1
• PCV	4
• Polio	3
• Varicella (chickenpox)	1


Required immunizations for Kindergarten – 12th Grade attendance

Vaccine

- DTaP
- **Hepatitis A**
- Hepatitis B
- **HPV***
- **MCV***
- MMR
- Polio
- **Tdap***
- Varicella (chickenpox)

Number of Doses

- 5
- 2
- 3
- 2-3*
- 1*
- 2
- 4
- 1*
- 2

 **TABLE 2: REQUIRED IMMUNIZATIONS – GRADES KINDERGARTEN – 12***

By This Grade	Students are Required to Have								
	DTaP (Diphtheria, Tetanus, Pertussis)	Polio	Hepatitis B	Hepatitis A	MMR (Measles, Mumps, Rubella)	Varicella (Chickenpox)	HPV (Human Papillomavirus Vaccine)	MCV (Meningococcal Conjugate Vaccine)	Tdap (Tetanus, Diphtheria, Pertussis)
All Kindergarten Students and New Enters in Grades 1 – 6	5 doses	4 doses	3 doses	2 doses	2 doses	2 doses	Not required for this grade	Not required for this grade	Not required for this grade
7 th Grade Attendance							2 doses	1 dose	1 dose
All New Enters in Grades 7 – 12	5 doses	4 doses	3 doses	2 doses	2 doses	2 doses	2 or 3 doses [†]	1 dose [†]	1 dose

*See Table 6: Exceptions to Immunization Requirements

[†]Age 9 through 14 years at initial vaccination: 2 doses of HPV required
Age 15 years or older at initial vaccination: 3 doses of HPV required

[†]Age 10 through 15 years upon new entrance: 1 dose of MCV required
Age 16 years and older upon new entrance: At least 1 dose of MCV on or after age 16 years required, a minimum of 8 weeks after a previous dose

*HPV, MCV, & Tdap vaccines not required for students entering Hawaii schools in Kindergarten – 6th grade

Required immunizations for 7th Grade attendance*

<u>Vaccine</u>	<u>Number of Doses</u>
• HPV	2
• MCV	1
• Tdap	1

*In addition to meeting the Kindergarten – 12th Grade immunization requirements upon first school attendance, ALL students must have documentation of these vaccinations prior to 7th grade attendance

Immunizations

- Must meet *minimum* age and *minimum* interval requirements
 - There is no maximum interval between doses. If doses are given later than recommended intervals, they are acceptable.
- Grace period: Vaccine doses administered ≤ 4 days before minimum age or interval are considered valid unless otherwise specified
 - 4-day grace period does NOT apply to interval between two different live virus vaccines (e.g., MMR and varicella)
 - If not given on same day, minimum interval of 4 weeks required between two doses of different live virus vaccines

Documentation of Immunizations - Requirements

- Complete date (month/day/year)
- Name of practitioner*
- Signature or stamp of practitioner*

*A “practitioner” is a physician, APRN, or physician assistant licensed to practice in any of the states or territories of the United States.

Note: Records of immunizations not administered in U.S. may be accepted if reviewed and signed/stamped by a practitioner

Serologic (blood test) Evidence of Immunity – Requirements

- Laboratory evidence of immunity may be substituted for a record of immunization.
- Only applies to certain diseases (refer to [Immunization Requirements Summary](#))
- Copy of laboratory report, signed by practitioner
 - Practitioner must certify student is immune to named disease(s)

<https://health.hawaii.gov/docd/files/2019/10/Immunization-Requirements-Summary.pdf>

History of varicella (chickenpox)

- A documented history of varicella, signed by practitioner may be substituted for the varicella vaccine requirement.

Child Care Facility and School Responsibility

- Each child care facility and school principal or administrator shall only admit students who meet the health requirements in HAR 11-157

Exemptions that can be applied to immunizations:

- Medical
- Religious

No other exemptions (e.g., personal belief, philosophical) are allowed.

During an outbreak, exemptions are NOT recognized:

- Inadequately immunized students will be excluded from child care facilities and schools until outbreak is over

Exemptions

- Medical
 - Contraindication or precaution to vaccine, in conformance with recognized standard medical practices
 - Specific period of time
 - Signed by practitioner on form specified by HDOH

Medical Exemption Form

Instructions for completing Medical Exemption Form:
 Section 1: Completed by parent/guardian or student (aged ≥18 years): Enter child care facility, school, or post-secondary school, and student information
 Section 2: Completed by licensed health care provider (MD, DO, ND, APRN-Rx, PA): Check exempted vaccine, contraindication or precaution, or both, and complete duration of exemption

Section 1: Child Care Facility, School, Post-Secondary School, and Student Information

Student's Name: _____ Student's Date of Birth: _____

Student's Home Address: _____ City: _____ State: _____ Zip: _____

Name of Child Care Facility, School, Post-Secondary School: _____ Street Address: _____ City: _____ Zip: _____

I understand that if at any time there is, in the opinion of the Department of Health, danger of an outbreak or epidemic from any communicable disease for which immunization is required, this exemption from immunization shall not be recognized and the student named above will be excluded from attending the child care facility, school, or post-secondary school until the Director of Health has determined that the presence of the outbreak no longer exists (HRS §302a-1137).

Parent/Guardian Name (if student <18 years): (Please print): _____ Date: _____

Parent/Guardian on Student (if aged ≥18 years): Signature: _____ Date: _____

Section 2: For Health Care Provider Use ONLY (MD, DO, ND, APRN-Rx, PA):

Vaccine	Contraindications* (Check all that apply to this patient)	Precautions* (Check all that apply to this patient)	From:	To:
<input type="checkbox"/> DTaP	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	<input type="checkbox"/> Guillain-Barre Syndrome <6 weeks after previous dose of tetanus-toxoid-containing vaccine	/	/ /
<input type="checkbox"/> Tdap	<input type="checkbox"/> DTaP/Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures), not attributable to another identifiable cause, within 7 days of administration of previous dose	<input type="checkbox"/> History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid-containing or tetanus-toxoid-containing vaccine	/	/ /
<input type="checkbox"/> DT, Td	<input type="checkbox"/> Moderate or severe acute illness with or without fever	<input type="checkbox"/> Moderate or severe acute illness with or without fever	/	/ /
<input type="checkbox"/> Hib	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	<input type="checkbox"/> Moderate or severe acute illness with or without fever	/	/ / /
<input type="checkbox"/> Hep A	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	<input type="checkbox"/> Moderate or severe acute illness with or without fever	/	/ / /
<input type="checkbox"/> Hep B	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	<input type="checkbox"/> Moderate or severe acute illness with or without fever	/	/ / /

*https://health.hawaii.gov/docd/files/2019/08/HAR11-157_EXHIBIT_B.pdf

State of Hawaii Department of Health
EPI 8 UPDATED October 2019

Student's Name: _____ Student's Date of Birth: _____

Section 2: For Health Care Provider Use ONLY (MD, DO, ND, APRN-Rx, PA):

Vaccine	Contraindications* (Check all that apply to this patient)	Precautions* (Check all that apply to this patient)	From:	To:
<input type="checkbox"/> HPV	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	<input type="checkbox"/> Pregnancy	/	/ / /
<input type="checkbox"/> MMR	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	<input type="checkbox"/> Recent (<11 months) receipt of antibody-containing blood product	/	/ / /
<input type="checkbox"/> MCV	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	<input type="checkbox"/> History of thrombocytopenia or thrombocytopenic purpura	/	/ / /
<input type="checkbox"/> PCV	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose of PCV13 or any diphtheria-toxoid-containing vaccine or to a component of a vaccine (PCV13) or any diphtheria-toxoid-containing vaccine	<input type="checkbox"/> Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing	/	/ / /
<input type="checkbox"/> IPV	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	<input type="checkbox"/> Moderate or severe acute illness with or without fever	/	/ / /
<input type="checkbox"/> Varicella	<input type="checkbox"/> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	<input type="checkbox"/> Recent (<11 months) receipt of antibody-containing blood product	/	/ / /

I certify that in my medical judgement, due to the contraindication(s)/precaution(s) noted above, this student is exempt from the specific vaccine(s) named for the period indicated.

Health care provider's name/Title (Please Print): _____ License number: _____

Address: _____ Date: _____

Health care provider's signature: _____


Give completed original form to parent/guardian or student (aged ≥18 years). Send copy of form to: State of Hawaii Department of Health, Immunization Branch, P.O. Box 3378, Honolulu, HI 96808 OR Fax to (808) 586-8342.

*DTaP: Diphtheria, Tetanus, and Pertussis; Hib: Human papillomavirus; MMR: measles, mumps, rubella; MCV: meningococcal conjugate vaccine; PCV: pneumococcal conjugate vaccine; IPV: inactivated poliovirus vaccine; Hep B: Hepatitis B; HPV: human papillomavirus; MMR: measles, mumps, rubella; MCV: meningococcal conjugate vaccine; PCV: pneumococcal conjugate vaccine; IPV: inactivated poliovirus vaccine

State of Hawaii Department of Health
EPI 8 UPDATED October 2019

Exemptions

- Religious
 - Must certify religious beliefs prohibit the practice of immunization
 - Request for religious exemption based on objections to specific immunizing agents will not be granted

 REQUEST FOR EXEMPTION FROM VACCINATION ON RELIGIOUS GROUNDS			
Student's Name:		Student's Date of Birth:	
Student's Home Address:		City	Zip
Name of Child Care Facility or School:	Street Address:	City	Zip
I certify that immunization conflicts with my bona fide religious tenets and practices. Initials: _____			
I understand that if at any time there is, in the opinion of the Department of Health, danger of an outbreak or epidemic from any communicable disease for which immunization is required, this exemption from immunization shall not be recognized and my child will be excluded from school or his/her child care facility until the threat of an epidemic is over or he/she receives the proper immunization. Initials: _____			
I understand that a request for religious exemption based on objections to specific vaccines will not be granted. Initials: _____			
I understand the benefits and risks of the vaccinations my child is required to have for school/child care facility attendance, the risk of my child contracting the diseases that vaccines prevent, and the risk of my child transmitting disease to others. I understand that this form may not be used for personal or philosophical reasons.			
Parent/Guardian Name (please print) _____		Date: _____	
Parent/Guardian Signature _____			
Hawaii Revised Statutes: §302A-1156, §302A-1157, §325-34 Hawaii Administrative Rules: §11-157-5			

State of Hawaii Department of Health
Epi 7A September 2019

Provisional attendance

- Students who have not completed physical examination or received all required vaccines:
 - May attend school provisionally AFTER submitting an appointment slip from practitioner's office
 - Parent/guardian must be notified re: provisional attendance (EPI 10B)
 - Provisional attendance period: no longer than 3 months after date of provisional attendance

School: _____ Date: _____

PROVISIONAL ENTRANCE NOTICE

To the Parent/Guardian of: _____ Birth Date: _____ Grade _____
Your child has been allowed to enter school on ____/____/____ on a provisional (temporary) status.
According to our records, your child is missing the following requirements.

IMMUNIZATIONS

		Missing Dose	Dose does not meet minimum age/interval requirements
DTaP	[Dose Number(s)] _____	<input type="checkbox"/>	<input type="checkbox"/>
Polio	[Dose Number(s)] _____	<input type="checkbox"/>	<input type="checkbox"/>
Hib (Preschool only)	[Dose Number(s)] _____	<input type="checkbox"/>	<input type="checkbox"/>
PCV (Preschool only)	[Dose Number(s)] _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	[Dose Number(s)] _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A	[Dose Number(s)] _____	<input type="checkbox"/>	<input type="checkbox"/>
MMR	[Dose Number(s)] _____	<input type="checkbox"/>	<input type="checkbox"/>
Varicella*	[Dose Number(s)] _____	<input type="checkbox"/>	<input type="checkbox"/>
HPV (7 th grade only)	[Dose Number(s)] _____	<input type="checkbox"/>	<input type="checkbox"/>
MCV (7 th grade only)	[Dose Number(s)] _____	<input type="checkbox"/>	<input type="checkbox"/>
Tdap (7 th grade only)	[Dose Number(s)] _____	<input type="checkbox"/>	<input type="checkbox"/>

*A documented history of varicella (chickenpox) disease, signed by a U.S. licensed physician, advanced practice registered nurse, or physician's assistant may be substituted for the varicella vaccine requirement.

PHYSICAL EXAMINATION
Performed by a U.S. licensed physician, advanced practice registered nurse, or physician's assistant within 12 months prior to the date of preschool or school entry.

Certification that the above requirements have been completed must be submitted to the schools **NO LATER THAN** _____. If certification is not received by this date, your child will be excluded from school.

NOTE: Provisional entrance may be suspended when there is a danger of an epidemic from any communicable disease for which immunization is required. Your child will not be permitted to attend school unless he/she receives the required immunization or until the epidemic is over.

If you have any questions, please call the school health aide at _____.

Principal _____ EPI 10B 06/20

Provisional attendance

- If student fails to keep scheduled appointment, must submit a new appointment slip to attend child care facility or school
- Failure to keep appointment does not extend provisional attendance period
- If all required immunizations cannot be administered within provisional attendance period due to minimum intervals between doses or other medical necessity, the provisional attendance period may be extended as long as appointment slip to receive required immunization(s) has been submitted.

Provisional attendance

- Provisional attendance may be suspended during an outbreak

Exclusion

- If student does not complete physical examination or immunizations within 3 months of the date of provisional attendance:
 - Notify parent in writing that student will be excluded in 30 days (EPI 10D)
 - Beginning 30 calendar days after date of notice of exclusion, child care facility or school shall prohibit student from attending until documentation of physical examination and immunizations provided

School: _____ Date: _____

NOTICE OF EXCLUSION

To the Parent/Guardian of: _____ Birth Date: _____ Grade _____

School health laws require that students receive a physical examination and immunizations before entering/attending preschool or school in Hawaii.

According to our records, your child is still missing the following requirements:

IMMUNIZATIONS

	Missing Dose	Dose does not meet minimum age/interval requirements
DTaP [Dose Number(s) _____]	<input type="checkbox"/>	<input type="checkbox"/>
Polio [Dose Number(s) _____]	<input type="checkbox"/>	<input type="checkbox"/>
Hib (Preschool only) [Dose Number(s) _____]	<input type="checkbox"/>	<input type="checkbox"/>
PCV (Preschool only) [Dose Number(s) _____]	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B [Dose Number(s) _____]	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A [Dose Number(s) _____]	<input type="checkbox"/>	<input type="checkbox"/>
MMR [Dose Number(s) _____]	<input type="checkbox"/>	<input type="checkbox"/>
Varicella* [Dose Number(s) _____]	<input type="checkbox"/>	<input type="checkbox"/>
HPV (7 th grade only) [Dose Number(s) _____]	<input type="checkbox"/>	<input type="checkbox"/>
MCV (7 th grade only) [Dose Number(s) _____]	<input type="checkbox"/>	<input type="checkbox"/>
Tdap (7 th grade only) [Dose Number(s) _____]	<input type="checkbox"/>	<input type="checkbox"/>

*A documented history of varicella (chickenpox) disease, signed by a U.S. licensed physician, advanced practice registered nurse, or physician's assistant may be substituted for the varicella vaccine requirement.

PHYSICAL EXAMINATION
Performed by a U.S. licensed physician, advanced practice registered nurse, or physician's assistant within 12 months prior to the date of school entry.

Your child provisionally entered school on _____ and has been allowed three months to complete the above requirements. The school has not received certification that these health requirements have been met.

Please arrange with your child's doctor to complete these requirements as soon as possible and provide the school with certification of their fulfillment. **If these requirements are not completed, your child will be denied further attendance at school on _____ (Hawaii Administrative Rules 302A-1162).**

If you have any questions or difficulty meeting these requirements, please call the school health aide at _____.

Principal

EPI 10D 06/20

Note: Exclusion does not apply to 7th grade physical examination requirement.

Reporting

- Each child care facility and school must report to HDOH, students who have:
 - Been provisionally admitted
 - Includes type of immunization(s) which are incomplete and dose numbers
 - Medical exemption
 - Religious exemption
 - Been excluded for failure to comply with PE and immunization requirements
- Reports are due on **October 10th** and **January 10th** of each school year
- Report must be submitted even if all students have met the immunization and examination requirements



Thank you!

If you have any questions, please call the
Immunization Branch at (808) 586-8300.