

# KANSAS CERTIFICATE OF IMMUNIZATIONS (KCI)

*This record is part of the student's permanent record and shall be transferred from one school to another as defined in Section 72-5209 (d) of the Kansas School Immunization Law (amended 1994.)*

Student Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 Parent or Guardian Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_

Birthdate (MM/DD/YYYY): \_\_\_\_\_ SEX: [ ] MALE [ ] FEMALE Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ County \_\_\_\_\_

<b>VACCINE</b>	RECORD THE MONTH, DAY, AND YEAR THAT EACH DOSE OF VACCINE WAS RECEIVED						
	1st	2nd	3rd	4th	5th	6th	7th
<b>DTaP/DT/Td/Tdap</b> (Diphtheria, Tetanus, Pertussis) Required for school entry.							
<b>Polio</b> Required for school entry.							If additional doses are added, please initial the dose and sign below: _____ _____ _____
<b>HEP B</b> (Hepatitis B) Required through Grade 5 for 2008-09 school year. Recommended for all children.							
<b>Varicella</b> (Chicken Pox) Required through Grade 5 for 2008-09 school year. Recommended for all children.				Hx of Disease: _____ Date of Illness: _____ Parent/Physician Signature: _____			
<b>MMR</b> (Measles, Mumps, and Rubella combined) Required for school entry.							
<b>HIB</b> (Haemophilus Influenzae Type B) Recommended < 5 yrs; not required for school entry.							
<b>PCV7</b> (Pneumococcal Conjugate) Recommended < 5 yrs; not required for school entry.							
<b>HEP A</b> (Hepatitis A) Recommended; not required for school entry.							
<b>MCV4</b> (Meningococcal) Recommended >= 11 yrs; not required for school entry.							
<b>HPV</b> (Human Papillomavirus) Recommended >= 11 yrs; not required for school entry.							
<b>Rotavirus</b> Recommended < 8 mo of age; not required for school entry.							
<p style="text-align: center;"><b>DOCUMENTATION</b></p> <p>PARENTS AND/OR GUARDIANS ARE NOT AUTHORIZED TO COMPLETE KCI FORM.</p> <p><input type="checkbox"/> I certify I reviewed this student's vaccination record and transcribed it accurately</p> <p>Clinic Name: _____                      Physician's Name: _____                      Address: _____</p> <p>The record presented was: _____ Date _____</p> <p><input type="checkbox"/> Kansas Immunization Record  <input type="checkbox"/> Other Immunization Record (Specify) _____</p>	<p style="text-align: center;"><b>LEGAL ALTERNATIVES TO VACCINATION REQUIREMENTS</b></p> <p><input type="checkbox"/> 1. Annual Medical Exemption: Must be provided by a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.). Complete the information below, as well as the affidavit on the reverse side. Medical exemptions shall be documented annually on KCI Form B and attached to this record.</p> <p style="text-align: center;">* Annual Medical Exemption for pertussis required for DT until 7 years of age.</p> <p style="text-align: center;"> <input type="checkbox"/> DTaP      <input type="checkbox"/> Pertussis only      <input type="checkbox"/> MMR      <input type="checkbox"/> Other _____  <input type="checkbox"/> IPV      <input type="checkbox"/> HEP B      <input type="checkbox"/> Varicella                 </p> <p><input type="checkbox"/> 2. Religious Exemption: Parent or guardian must complete the affidavit on the reverse side.</p>						

KANSAS IMMUNIZATION PROGRAM  
 1000 SW Jackson, Suite 210, Topeka, KS 66612-1274  
 PHONE 785-296-5591 FAX 785-296-6510  
 WEB SITE [www.kdheks.gov/immunize](http://www.kdheks.gov/immunize)

I give my consent for information contained on this form to be released to the Kansas Immunization Program for the purpose of assessment and reporting.

\_\_\_\_\_  
 Parent/Legal Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_ Rev. April, 2008

**KANSAS IMMUNIZATION REQUIREMENTS: Based on age of child as of September 1 of current school year.**

**As per Kansas Statute 72-5209, all children upon entry to school must be appropriately vaccinated. In each column below, vaccines are required for all ages listed in that column.**

Ages 0-4	Ages 5-6	Ages 7-18
<p><b>Recommended Schedule</b></p>	<p><b>DTaP/*DT: 5 doses</b></p>	<p><b>Td: 3 doses if series started after 7 years of age</b></p>
<p>Birth <b>HEP B</b></p> <p>2 Months <b>DTaP/DT POLIO HEP B HIB PCV7 ROTAVIRUS</b></p>	<p>a) 4 week minimum interval between doses, with at least 6 months between dose 3 and dose 4.</p> <p>b) 4 doses acceptable if dose 4 given on or after the 4th birthday.</p> <p>c) If dose 4 is administered before the 4th birthday, a 5th dose must be given at 4-6 years of age.</p> <p>* If 1st DT dose given at &lt;12 months of age, 4 doses recommended; acceptable only when Pertussis component is contraindicated by the physician.</p> <p>* If 1st DT dose given at 12 months or older, 3 doses complete primary series; acceptable only when Pertussis component is contraindicated by the physician.</p> <p>The limit for DTaP vaccine is 6 doses, regardless of schedule.</p>	<p>a) 4 week minimum interval between dose 1 and 2.</p> <p>b) 6 month interval between dose 2 and dose 3.</p> <p>c) Booster required 10 years after completion of the DTaP/DT/Td primary series. The first booster may be given as early as 11-12 years of age if at least 5 years after the last DTaP/DT/Td. If a dose is given sooner as part of wound management, the next booster is not needed for 10 years.</p> <p>d) Tdap is recommended for the 10 year booster. Tetanus toxoid alone does not meet the Td 10-year booster requirements.</p>
<p>4 Months <b>DTaP/DT POLIO HIB PCV7 ROTAVIRUS</b></p>	<p><b>POLIO:</b></p> <p><b>4 doses of POLIO are acceptable IF:</b></p> <p>a) 4 week minimum interval between doses, regardless of age given.</p> <p><b>3 doses of POLIO (all IPV) are acceptable IF:</b></p> <p>a) 4 week minimum interval between each dose, with 1 dose given on or after the 4th birthday.</p> <p>The limit for POLIO vaccine is 5 doses, regardless of schedule.</p>	<p><b>POLIO - All IPV or OPV Schedule</b></p> <p><b>4 doses of POLIO are acceptable IF:</b></p> <p>a) 4 week minimum interval between doses, regardless of age given.</p> <p><b>3 doses of POLIO are acceptable IF:</b></p> <p>a) 4 week minimum interval between each dose, with 1 dose given on or after the 4th birthday.</p>
<p>6 Months <b>DTaP/DT POLIO HEP B HIB PCV7 ROTAVIRUS</b></p>	<p><b>MMR: 2 doses</b></p> <p>a) First dose must be on or after the 1st birthday.</p> <p>b) 4 week minimum interval between doses.</p> <p>Single antigen measles vaccine will not meet requirements without the addition of mumps and rubella vaccine.</p>	<p><b>POLIO - IPV/OPV Combination Schedule</b></p> <p><b>4 doses of POLIO are acceptable IF:</b></p> <p>a) 4 week minimum interval between each dose, regardless of age given. Three doses of a combination schedule are NOT acceptable.</p> <p>The limit for POLIO vaccine is 5 doses, regardless of schedule.</p>
<p>12-15 Months <b>DTaP/DT MMR VAR HIB PCV7 HEP A</b></p>	<p><b>VARICELLA: 1 dose **required through Grade 5 for 2008-09 school year</b></p> <p>a) First dose must be on or after the 1st birthday.</p> <p>b) None required if prior varicella disease verified.</p> <p>c) Two doses are <i>recommended</i> for all children.</p>	<p><b>MMR: 2 doses</b></p> <p>a) First dose must be on or after the 1st birthday.</p> <p>b) 4 week minimum interval between doses.</p> <p><b>VARICELLA: 1 dose **required through Grade 5 for 2008-09 school year</b></p> <p>a) First dose must be on or after the 1st birthday.</p> <p>b) None required if prior varicella disease verified.</p> <p>c) Two doses are <i>recommended</i> for all children.</p>
<p>Recommendations are based on the ACIP recommended schedule.</p> <p><a href="http://www.cdc.gov/vaccines/recs/schedules">www.cdc.gov/vaccines/recs/schedules</a></p>	<p><b>HEPATITIS B: 3 doses **required through Grade 5 for 2008-09 school year</b></p> <p>a) 4 week minimum interval between dose 1 and dose 2.</p> <p>b) 8 week minimum interval between dose 2 and dose 3.</p> <p>c) 16 week minimum interval between dose 1 and dose 3.</p> <p>Dose 3 must be given after 24 wks of age.</p>	<p><b>HEPATITIS B: 3 doses **required through Grade 5 for 2008-09 school year</b></p> <p>a) 4 week minimum interval between dose 1 and dose 2.</p> <p>b) 8 week minimum interval between dose 2 and dose 3.</p> <p>c) 16 week minimum interval between dose 1 and dose 3.</p> <p>d) Dose 3 must be given after 24 wks of age.</p>

\*\*The Hepatitis B and Varicella requirements for schools, as specified in K.A.R. 28-1-20, are being phased in. Additional grades will be added each school year until students of all ages are included in the requirements.

Vaccine doses given up to 4 days before the minimum interval or age may be considered valid.

With the exception of Hepatitis B vaccine, immunizations given before 6 weeks of age are not considered valid.

Half doses or reduced doses of vaccine are not considered valid.

**PARENTS AND/OR GUARDIANS ARE NOT AUTHORIZED TO COMPLETE KCI FORMS.**

Must be documented annually by a physician, their office personnel, a health department representative, or a designated school representative. Parents or guardians may complete the religious exemption section only.

**1. Medical Exemption signed by a Medical Doctor (M.D.) or a Doctor of Osteopathy (D.O.)**

Signature \_\_\_\_\_

Medical License # \_\_\_\_\_ State of Licensure \_\_\_\_\_

Name (print) \_\_\_\_\_

Telephone Number ( ) \_\_\_\_\_ Date of Licensure \_\_\_\_\_

**2. Religious Exemption signed by the Parent or Guardian.**

Signature \_\_\_\_\_

Date \_\_\_\_\_ Relationship \_\_\_\_\_

**A ROSTER WITH THE NAMES OF ALL EXEMPT STUDENTS SHOULD BE MAINTAINED. THE PARENTS OR GUARDIANS OF EXEMPT CHILDREN SHOULD BE INFORMED THAT THEIR CHILDREN SHALL BE EXCLUDED FROM SCHOOL IN THE EVENT OF AN OUTBREAK OR SUSPECTED CASE OF A VACCINE-PREVENTABLE DISEASE.**