



Health and Wellness
Together we can do more!

Western Community Health Resources

Chadron Community Hospital Corporation

Western Community Health Resources

300 Shelton St

Chadron, NE 69337

(800) 717-1231 or (308) 432-8979



Dear Parents,

Western Community Health Resources would like to provide you with this reminder that it is time to update vaccinations for students entering Kindergarten, 7th grade, also 11th and 12th grades. WCHR is offering a vaccination clinic in Hay Springs at the Lister-Sage gym on the morning of May 5th from 9:00 am to 11:30 am. We will be able to review your student's current vaccine record and offer any vaccines they may need.

Please refer to the attached form for vaccinations that are; "required/recommended" for the appropriate grade your student will be entering this next school year. Also included is the "proxy" form which you may fill out and return to the school which will allow WCHR to provide the vaccinations, approved by YOU, the parent, IF you are unable to attend event with your student. WCHR will then mail out updated vaccine records.

The summer will be here soon. Agendas may consist of individual or team camps, vacations, and family reunions. All potential activities that increase your child's exposure to viruses and bacteria.

If you will be unable to make the clinic on May 5th, WCHR in Chadron offers 2 regular clinics each month on the 1st and 4th Tuesdays from 2pm to 6pm. You can call and schedule an appointment if that would work better. PLEASE remember to bring your most current insurance card to your appointment.

Feel free to call us with any questions or concerns you may have. If your child has received vaccines from another provider, let us know and we will be glad to update their record in Nebraska State data base. The Nesiis system is the data base used by all state school districts.

Have a great Summer Break.

Stephani Pelton, LPN

Western Community Health Resources Immunization Clinic Manager

Immunization Requirements for the 2023-2024 School Year

K.A.R. 28-1-20 defines immunizations required for any individual who attends school or a childcare program operated by a school. Below are the requirements for the indicated school year. Please carefully review the requirements. The usual number of doses required are listed; however there are exceptional circumstances that could alter the number of doses a child needs. If you have questions about your child's immunization status, contact your child's primary care provider or local health department.



Proof of receiving the required immunizations must be provided to the school prior to the student attending the first day of school.

Early Childhood Program Operated by a School Ages 4 Years and Under

Vaccine	Requirement
DTaP/DT (diphtheria, tetanus, pertussis)	4 doses
IPV (polio)	3 doses
MMR (measles, mumps, rubella)	1 dose
Varicella (chickenpox)	1 dose*
Hepatitis A	2 doses
Hepatitis B	3 doses
Hib (haemophilus influenza type B)	4 doses**
Prevnar (pneumococcal conjugate)	4 doses**

KDG - Grade 3 New Requirement!

Vaccine	Requirement
DTaP/DT (diphtheria, tetanus, pertussis)	5 doses
IPV (polio)	4 doses ***
MMR (measles, mumps, rubella)	2 doses
Varicella (chickenpox)	2 doses*
Hepatitis A - New Requirement!	2 doses
Hepatitis B	3 doses

Grades 4 - 6

Vaccine	Requirement
DTaP/DT (diphtheria, tetanus, pertussis)	5 doses
IPV (polio)	4 doses ***
MMR (measles, mumps, rubella)	2 doses
Varicella (chickenpox)	2 doses*
Hepatitis B	3 doses

Grade 7 - 8 New Requirement!

Vaccine	Requirement
Tdap (tetanus, diphtheria, pertussis)	1 dose~
IPV (polio)	4 doses ***
MMR (measles, mumps, rubella)	2 doses
Varicella (chickenpox)	2 doses*
Hepatitis B	3 doses

NEW Requirement!

Additional ACIP RECOMMENDED Vaccines Not Required for School Entry

- **Influenza (Flu):** Annual vaccine recommended for everyone 6 months of age and older.
- **HPV (Human Papillomavirus) Vaccine:**
2 doses recommended at age 11 years
2 doses needed if started at 11-14 years
3 doses needed if started at 15 years or older

Grades 9 - 12

Vaccine	Requirement
Tdap (tetanus, diphtheria, pertussis)	1 dose~
IPV (polio)	4 doses ***
MMR (measles, mumps, rubella)	2 doses
Varicella (chickenpox)	2 doses*
Hepatitis B	3 doses

Grade 11 - 12 New Requirement! In addition to above vaccines for Grades 9 - 12

Meningococcal (serogroup A, C, W, Y)	1-2 doses <i>See Below</i>
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If only one dose has been received, and it was before the age of 16, a second dose is required.

If one dose is received at age 16 or older, no additional doses are required.

Notes

* Varicella (chickenpox) vaccine is not required if child has had chickenpox disease **and** disease is documented by a physician signature. Without physician signature, vaccine is still required even if you believe your child has had chickenpox disease.

**Total doses needed are dependent on vaccine type and age the doses were administered.

***All Students in grades K-8, all new students and students currently completing the polio series must have 6 months between the last 2 doses of polio vaccine, and one dose must be after the 4th birthday.

~All students in grades 7-12 must have one dose of Tdap

VACCINE DOCUMENTATION/CONSENT FORM

I have been given the information/access*** to review the Vaccine Information Statement(s) (VIS) checked below. I have had the chance to read, or have explained to me by the medical personal/agency, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to the person named below for whom I am authorized to make this request. I consent to inclusion of this Immunization data in the Nebraska State Immunization Information System (NESIIS) on behalf of the person names below.

DT DTaP Tdap Td HepA HepB Hib HPV Influenza Meningococcal
 MMR PCV13 PPV23 Polio/IPV Rotavirus Varicella Other _____

Signature of Patient or Parent/Guardian _____ **Date** _____

Name of Primary Care Physician: _____

PATIENT INFORMATION				
Patient's Last Name:	Patient's First Name:	Phone Number:	Age:	Birth Date:
Street Address:	City:	County:	State:	Zip Code:
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> YES <input type="checkbox"/> NO Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Race: (Select one or more) <input type="checkbox"/> AS-Asian/Pacific Islander/Other <input type="checkbox"/> HA-Hawaiian <input type="checkbox"/> BL-Black or African American <input type="checkbox"/> IN-Native American/Alaska Native <input type="checkbox"/> CA-Caucasian/Mexican/Puerto Rican		
PATIENT ELIGIBILITY				
<input type="checkbox"/> Medicaid	<input type="checkbox"/> No health insurance	<input type="checkbox"/> Underinsured*	<input type="checkbox"/> Native Am/Alaska Native	<input type="checkbox"/> Fully Insured

*Underinsured children: insurance does not cover immunizations. Eligible through VFC program if vaccinated at a FQHC, RHC, or delegated county health department.

IMMUNIZATION SCREENING QUESTIONNAIRE	
1. Is the patient to be vaccinated currently sick or experiencing a high fever?	__ yes __ no
2. Does the patient have allergies to medications, food, a vaccine component, or latex?	__ yes __ no
3. Has the patient has a serious reaction to a vaccine in the past?	__ yes __ no
4. Has the patient had a health problem with a lung, heart, kidney, or metabolic disease (e.g. diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	__ yes __ no
5. If the patient to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	__ yes __ no
6. If the patient is a baby, have you ever been told he or she has had intussusceptions?	__ yes __ no
7. Has the patient, a sibling, or parent had a seizure; has the child had brain or nervous system problems?	__ yes __ no
8. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	__ yes __ no
9. In the past 3 months, has the patient taken medication that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	__ yes __ no
10. In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	__ yes __ no
11. Is the patient pregnant or is there a chance she could become pregnant during the next month?	__ yes __ no
12. Has the patient received vaccinations in the past 4 weeks?	__ yes __ no

***website for VIS sheets: www.cdc.gov/vaccines/index.html