**SPOTSYLVANIA COUNTY SCHOOLS**
**Tdap Form**

## Certification of Immunization

***Section I***
**To be completed by a physician, registered nurse, or health department official.**
**See Section II for conditional enrollment and exemptions.**

Virginia State law (*Code of Virginia* 32.146) requires all sixth grade students to receive a booster tetanus, diphtheria, pertussis (Tdap) vaccine prior to entering school. This requirement applies to sixth grade students who have not received a tetanus toxoid-containing vaccine in the last five years. A copy of an immunization record signed by a Medical Provider or Health Department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form. If this form is used it must be signed and dated by the Medical Provider or Health Department official in the appropriate box.

Student's Name: _____ Date of Birth: _____/_____/_____
*Last* *First* *Middle* *Mo. Day Yr.*

| IMMUNIZATION | RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN | | | | |
|---|---|---|---|---|---|
| *Diphtheria, Tetanus, Pertussis (DTP, DTaP) | **1** | **2** | **3** | **4** | **5** |
| *Diphtheria, Tetanus (DT) or Td (given after 7 years of age) | **1** | **2** | **3** | **4** | **5** |
| ***Tdap booster (6th grade entry)** | **MO/DAY/YR** | | | | |

I certify that this child is **ADEQUATELY IMMUNIZED** IN ACCORDANCE WITH Virginia State law (*Code of Virginia* 32.146) WHICH REQUIRES A TETANUS-TOXOID CONTAINING VACCINE FOR STUDENTS ENTERING 6TH GRADE.

**Signature of Medical Provider or Health Department Official: _____ Date (Mo., Day, Yr.): ____/____/____**

**Name of Medical Provider or Health Department Official: _____**

**Address:_____**

**Telephone #: _____ Fax #: _____**

***Section II***
***Exemptions***

Student's Name : _____ Date of Birth: _____

**MEDICAL EXEMPTION:** As specified in the *Code of Virginia §* 22.1-271.2, C (ii), I certify that the administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____

Tdap: [__]; DT/Td: [__]

This contraindication is permanent: [__], or temporary [__] and expected to preclude immunizations until: Date (Mo., Day, Yr.): ____/____/____

**Signature of Medical Provider or Health Department Official: _____ Date (Mo., Day, Yr.) : ____/____/____**

**RELIGIOUS EXEMPTION:** The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

**CERTIFICATE OF RELIGIOUS EXEMPTION**

Student's Name: _____ Date of Birth: ____/____/____
*Last* *First* *Middle* *Mo. Day Yr.*

The administration of immunizing agents conflicts with the above named student's/my religious tenets or practices. I understand, that in the occurrence of an outbreak, potential epidemic or epidemic of a vaccine preventable disease in my/my child's school, the State Health Commissioner may order my/my child's exclusion from school, for my/my child's own protection, until the danger has passed.

_____ _____
Signature of parent/guardian/student Date

I hereby affirm that this affidavit was signed in my presence on this _____ day of _____ .

*Notary Public Seal* _____
*Registration #* *(Signature)*