February 2020

Dear Parents/ Guardians,

The Ohio Department of Health School Immunization Requirements includes a **Tdap** booster and **Meningococcal vaccine before a student enters the seventh grade** to protect children from preventable diseases.

The **Tdap** vaccine will protect against pertussis (also known as whooping cough), a severe respiratory illness that causes violent rapid coughing that can last for extended periods of time.
The **Meningococcal** vaccine will protect your child against Meningococcal disease which is a serious life threatening vaccine-preventable infection. This bacterial infection can cause an inflammation of the lining of the brain and spinal cord or sepsis (an infection of the bloodstream).

Any student who received one dose of Tdap as part of the initial series or later received Tdap for an injury or other reason will meet this requirement and are not required to receive another dose for entry to 7th grade. Please supply us with the date below and return this form to the Perry Middle School office before the beginning of 2020-2021 school year.

You are receiving this notification letter now to provide you the opportunity to have your child immunized before the 2020-2021 school year begins. Please contact your doctor or the health department to schedule an appointment. Once your child has received these vaccines, please forward a copy of your child's immunization record to the school. **It is important to comply with this regulation, as it will be necessary to exclude your child from school attendance without Tdap booster and Meningococcal Vaccines.**

Also, in order to maintain an accurate immunization record for your child, please forward other updated immunization information. For more information or to schedule an appointment, contact your child's physician or the Lake County General Health District at 440.350.2554. If you have any questions, please contact district nurse, Susie McKoon, RN at 440-259-9671.

Please return to the office by the beginning of the 2020-2021 school year

_____ **Tday Booster:** _____/_____/_____
Student's Name **MM / DD / YYYY**

Meningococcal:_____/_____/_____
MM / DD / YYYY

_____ _____
Physician's Signature ***Date***