

# Oklahoma City Public Schools NEW STUDENT REGISTRATION FORM - PLEASE PRINT

|                                                                                                                                                                                                                                        |                                                                                                                |                                                                         |                                                                                                                                                                                                                                                                                  |         |                |                                                                                      |                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------|--------------------------------------------------------------------------------------|-----------------------------|
| STUDENT INFORMATION                                                                                                                                                                                                                    | STUDENT BIRTH CERTIFICATE NAME - LAST                                                                          |                                                                         | Jr., III, Etc.                                                                                                                                                                                                                                                                   | FIRST   | MIDDLE         | ENTERING GRADE                                                                       |                             |
|                                                                                                                                                                                                                                        | STUDENT NICKNAME/PREFERS TO BE CALLED                                                                          |                                                                         | SPECIAL CUSTODY/HEALTH PROBLEMS WE SHOULD BE AWARE OF:                                                                                                                                                                                                                           |         |                |                                                                                      |                             |
|                                                                                                                                                                                                                                        | STREET ADDRESS                                                                                                 |                                                                         |                                                                                                                                                                                                                                                                                  | APT/LOT | CITY/STATE/ZIP |                                                                                      |                             |
|                                                                                                                                                                                                                                        | HOME PHONE                                                                                                     | UNLISTED<br><input type="checkbox"/> YES<br><input type="checkbox"/> NO | MAILING ADDRESS - IF DIFFERENT                                                                                                                                                                                                                                                   |         |                |                                                                                      |                             |
|                                                                                                                                                                                                                                        | ETHNICITY (Choose one)<br><input type="checkbox"/> HISPANIC<br><input type="checkbox"/> NOT HISPANIC OR LATINO |                                                                         | RACE (Choose one or more)<br><input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> WHITE<br><input type="checkbox"/> ASIAN <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER<br><input type="checkbox"/> BLACK OR AFRICAN AMERICAN |         |                | SEX<br><input type="checkbox"/> MALE<br><input type="checkbox"/> FEMALE              | LANGUAGE SPOKEN IN THE HOME |
|                                                                                                                                                                                                                                        | DATE OF BIRTH                                                                                                  | DATE ENTERED U.S. SCHOOL                                                | BIRTH PLACE - City, State & Country                                                                                                                                                                                                                                              |         |                | FOREIGN EXCHANGE STUDENT<br><input type="checkbox"/> YES <input type="checkbox"/> NO |                             |
| IS YOUR STUDENT CURRENTLY BEING SERVED IN ANY SPECIAL PROGRAMS? (CHECK ALL THAT APPLY)<br><input type="checkbox"/> IEP <input type="checkbox"/> 504 PLAN <input type="checkbox"/> FOSTER CARE <input type="checkbox"/> GIFTED/TALENTED |                                                                                                                |                                                                         |                                                                                                                                                                                                                                                                                  |         |                |                                                                                      |                             |

|         |                             |                                                                                                                       |                                                |                                                 |
|---------|-----------------------------|-----------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------|
| TRANSIT | CHILD TRAVELS TO SCHOOL BY: | <input type="checkbox"/> CAR <input type="checkbox"/> WALK <input type="checkbox"/> BIKE <input type="checkbox"/> BUS | <input type="checkbox"/> Child Care Name _____ | <input type="checkbox"/> Child Care Phone _____ |
|         |                             |                                                                                                                       |                                                |                                                 |

|                                                                                                                                                             |                                                                                                                                                                                                                    |                                                                                                                                                             |                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--|
| FAMILY INFORMATION                                                                                                                                          | Student lives with: <input type="checkbox"/> Both parents <input type="checkbox"/> Mother only <input type="checkbox"/> Father only <input type="checkbox"/> Parent and Step Parent <input type="checkbox"/> Other |                                                                                                                                                             |                                                                    |  |
|                                                                                                                                                             | MOTHER / GUARDIAN 1    DOB _____ <input type="checkbox"/> PHOTO ID                                                                                                                                                 |                                                                                                                                                             | FATHER / GUARDIAN 2    DOB _____ <input type="checkbox"/> PHOTO ID |  |
|                                                                                                                                                             | NAME _____                                                                                                                                                                                                         |                                                                                                                                                             | NAME _____                                                         |  |
|                                                                                                                                                             | RELATIONSHIP _____                                                                                                                                                                                                 |                                                                                                                                                             | RELATIONSHIP _____                                                 |  |
|                                                                                                                                                             | PHONE: HOME _____                                                                                                                                                                                                  |                                                                                                                                                             | PHONE: HOME _____                                                  |  |
|                                                                                                                                                             | WORK _____                                                                                                                                                                                                         |                                                                                                                                                             | WORK _____                                                         |  |
| CELL _____                                                                                                                                                  |                                                                                                                                                                                                                    | CELL _____                                                                                                                                                  |                                                                    |  |
| SECONDARY ADDRESS (IF DIFFERENT FROM STUDENT) _____                                                                                                         |                                                                                                                                                                                                                    | SECONDARY ADDRESS (IF DIFFERENT FROM STUDENT) _____                                                                                                         |                                                                    |  |
| E-MAIL _____                                                                                                                                                |                                                                                                                                                                                                                    | E-MAIL _____                                                                                                                                                |                                                                    |  |
| <input type="checkbox"/> Armed Forces <input type="checkbox"/> National Guard <input type="checkbox"/> Reserves <input type="checkbox"/> Federally Employed |                                                                                                                                                                                                                    | <input type="checkbox"/> Armed Forces <input type="checkbox"/> National Guard <input type="checkbox"/> Reserves <input type="checkbox"/> Federally Employed |                                                                    |  |

|                                                              |                                                                      |                                                              |                    |  |
|--------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------|--------------------|--|
| EMERGENCY                                                    | <b>Emergency Contacts and Telephone - Other than Parent/Guardian</b> |                                                              |                    |  |
|                                                              | NAME _____                                                           |                                                              | NAME _____         |  |
|                                                              | RELATIONSHIP _____                                                   |                                                              | RELATIONSHIP _____ |  |
|                                                              | PHONE: HOME _____                                                    |                                                              | PHONE: HOME _____  |  |
|                                                              | WORK _____                                                           |                                                              | WORK _____         |  |
|                                                              | CELL _____                                                           |                                                              | CELL _____         |  |
| GENDER <input type="checkbox"/> M <input type="checkbox"/> F |                                                                      | GENDER <input type="checkbox"/> M <input type="checkbox"/> F |                    |  |
| <input type="checkbox"/> PHOTO ID                            |                                                                      | <input type="checkbox"/> PHOTO ID                            |                    |  |
| <input type="checkbox"/> CAN CHECK STUDENT OUT OF SCHOOL     |                                                                      | <input type="checkbox"/> CAN CHECK STUDENT OUT OF SCHOOL     |                    |  |
| DOB _____                                                    |                                                                      | DOB _____                                                    |                    |  |

|                                                                                                                                                                                                                                                                       |                                                  |  |                                                                                                                                                                                                              |  |                                                          |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------|--|
| PRIOR SCHOOL                                                                                                                                                                                                                                                          | NAME OF LAST SCHOOL or PRE-KINDERGARTEN ATTENDED |  | PREVIOUSLY ATTENDED                                                                                                                                                                                          |  | STUDENT EVER RETAINED                                    |  |
|                                                                                                                                                                                                                                                                       | City and State _____                             |  | Phone and Fax _____                                                                                                                                                                                          |  | <input type="checkbox"/> YES <input type="checkbox"/> NO |  |
|                                                                                                                                                                                                                                                                       |                                                  |  | <input type="checkbox"/> PUBLIC <input type="checkbox"/> CHARTER<br><input type="checkbox"/> PRIVATE <input type="checkbox"/> HOMESCHOOL<br><input type="checkbox"/> PAROCHIAL <input type="checkbox"/> NONE |  | IF YES, WHAT GRADE?                                      |  |
| IS THE STUDENT CURRENTLY UNDER SUSPENSION FROM ANOTHER SCHOOL DISTRICT? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>Students currently suspended from a school may not enroll until suspension has been served. Ask about alternative school options. |                                                  |  |                                                                                                                                                                                                              |  |                                                          |  |

|                |                                    |     |     |                |       |               |
|----------------|------------------------------------|-----|-----|----------------|-------|---------------|
| OTHER CHILDREN | <b>Other Children in Household</b> |     |     |                |       |               |
|                | Name                               | Age | Sex | Name of School | Grade | Date of Birth |
|                |                                    |     |     |                |       |               |

|                 |                                                 |                                            |                                          |                                           |                                                                   |  |
|-----------------|-------------------------------------------------|--------------------------------------------|------------------------------------------|-------------------------------------------|-------------------------------------------------------------------|--|
| SCHOOL USE ONLY | <b>STUDENT #</b> _____                          |                                            | <b>SCHOOL NAME</b> _____                 |                                           |                                                                   |  |
|                 | ENTRY DATE _____                                | ENTRY CODE _____                           | TEACHER/TEAM _____                       | BIRTH VERIFICATION _____                  |                                                                   |  |
|                 | <input type="checkbox"/> RESIDENCY VERIFICATION | <input type="checkbox"/> BIRTH CERTIFICATE | <input type="checkbox"/> PHYSICAL        | <input type="checkbox"/> TRANSFER PAPERS  | <input type="checkbox"/> ENROLLMENT QUESTIONNAIRE (HOMELESS FORM) |  |
|                 | <input type="checkbox"/> CUSTODY VERIFICATION   | <input type="checkbox"/> AGE VERIFICATION  | <input type="checkbox"/> LANGUAGE SURVEY | <input type="checkbox"/> PERMISSIONS FORM |                                                                   |  |

# STUDENT HEALTH ENROLLMENT

# Inscripción de Salud del Estudiante

**TO BE COMPLETED BY PARENT OR GUARDIAN AT TIME OF ENROLLMENT** Para ser completado por los padres o tutores al momento de la inscripción.

|                                                           |                                       |                               |                                                   |                                                 |
|-----------------------------------------------------------|---------------------------------------|-------------------------------|---------------------------------------------------|-------------------------------------------------|
| <b>STUDENT ID</b> <i>Nº de ID del estudiante</i>          | <b>RESIDENT SCHOOL</b> <i>Escuela</i> | <b>SCHOOL YEAR</b> <i>Año</i> | <b>GRADE LEVEL</b> <i>Grado</i>                   | <b>BIRTHDATE</b> <i>Fecha de Nacimiento</i>     |
| <b>STUDENT NAME</b> <i>Nombre del Estudiante</i>          |                                       |                               | <b>STUDENT GENDER</b> <i>Sexo</i>                 |                                                 |
|                                                           |                                       |                               | <input type="checkbox"/> Male <i>Masculino</i>    | <input type="checkbox"/> Female <i>Femenino</i> |
| <b>HOSPITAL PREFERENCE</b> <i>Hospital de Preferencia</i> | <b>PHYSICIAN</b> <i>Doctor</i>        |                               | <b>PHYSICIAN PHONE</b> <i>Teléfono del Doctor</i> |                                                 |
|                                                           |                                       |                               |                                                   |                                                 |

**Please check any conditions below that have been diagnosed or is an ongoing problem for your child:**

*Por favor marque enseguida cualquier condición que ha sido diagnosticada o es un problema actual de su hijo(a):*

|                                                                                     | Yes/Sí | No |                                                                                                        | Yes/Sí | No |
|-------------------------------------------------------------------------------------|--------|----|--------------------------------------------------------------------------------------------------------|--------|----|
| Hearing or Speech Problems<br><i>Problemas de audición o habla</i>                  |        |    | Vision problems (contacts/glasses/cataract)<br><i>Problemas Visuales (contactos/anteojos/catarata)</i> |        |    |
| Allergies (food/insects/medication)<br><i>Alergias (alimento/insectos/medicina)</i> |        |    | Anemia/Bleeding Problems/Sickle Cell<br><i>Anemia/Problemas de sangrado/Célula Falciforme</i>          |        |    |
| Tuberculosis / <i>Tuberculosis</i>                                                  |        |    | ADD/ADHD / TDA/TDAH                                                                                    |        |    |
| Anxiety/Depression / <i>Ansiedad/Depresión</i>                                      |        |    | Asthma* / <i>Asma*</i>                                                                                 |        |    |
| Heart Condition / <i>Condición Cardíaca</i>                                         |        |    | Seizures* / <i>Convulsiones*</i>                                                                       |        |    |
| Stomach Problems / <i>Problemas Estomacales</i>                                     |        |    | Cancer / <i>Cáncer</i>                                                                                 |        |    |
| Cystic Fibrosis / <i>Fibrosis Cística</i>                                           |        |    | Dental Problems / <i>Problemas Dentales</i>                                                            |        |    |
| Bladder/Bowel Problems<br><i>Problemas de la vejiga/intestinales</i>                |        |    | Head Injuries/ Head Aches/Migraines<br><i>Lesiones de la cabeza/Dolores de cabeza/Migrañas</i>         |        |    |
| Diabetes Type I or II*/Hypoglycemia<br><i>Diabetes Tipo I ó II*/Hipoglucemia</i>    |        |    | Hospitalizations/Surgeries<br><i>Hospitalizaciones/Cirugías</i>                                        |        |    |
| Other / <i>Otro</i>                                                                 |        |    | Other / <i>Otro</i>                                                                                    |        |    |

Please explain any 'Yes' answers from above/ *Si la respuesta en alguna de las anteriores es **SÍ**, por favor explique:*

\*Additional forms available for students with asthma, diabetes and seizure disorders.

\*Formas adicionales disponibles para estudiantes con desordenes de asma, diabetes y convulsiones.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Yes/Sí                                                                                                                                  | No |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|----|
| Does your child ever have to use an <b>Epi Pen</b> for allergies? <i>¿Alguna vez su hijo(a) ha usado un <b>Epi Pen</b> para las alergias?</i>                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                         |    |
| Does your child ever use an inhaler/breathing machine for breathing problems? (If yes, complete Medication permission form) <i>¿Alguna vez su hijo(a) ha usado un inhalador/máquina de respiración para problemas de respiración? (Si la respuesta es SI, complete la forma de permiso para medicina)</i>                                                                                                                                                                                                                                                                            |                                                                                                                                         |    |
| Does your child wear a hearing aid at school? <i>¿Su hijo(a) usa un dispositivo de ayuda auditiva en la escuela?</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                         |    |
| Does your child have any special health care needs? If yes, please explain:<br><i>¿Su hijo(a) tiene alguna necesidad especial de atención a la salud? Si la respuesta es si, por favor explique:</i>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                         |    |
| Would you like to schedule a meeting with the School Nurse? <i>¿Le gustaría hacer una cita con la Enfermera de la escuela?</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         |    |
| What <b>MEDICATIONS</b> does your child take <b>REGULARLY</b> ?<br><i>¿Qué <b>MEDICINAS</b> toma su hijo(a) <b>REGULARMENTE</b>?</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                 | What <b>MEDICATIONS</b> will your child take at <b>SCHOOL</b> ?<br><i>¿Qué <b>MEDICINAS</b> tomará su hijo(a) en la <b>ESCUELA</b>?</i> |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                         |    |
| <b>Students requiring ANY medication at school MUST have a current school year Medication Request and Release on file. Physician authorization and parental consent is required for any prescribed or over the counter medication to be given at school.</b> <i>Los estudiantes que necesiten alguna medicina en la escuela <b>DEBERÁN</b> tener Consentimiento y Autorización de Medicina vigente en los archivos de la escuela. La autorización del doctor y consentimiento de los padres son requeridos por cada medicina recetada o sin receta que se le dará en la escuela.</i> |                                                                                                                                         |    |

| <b>SIBLING NAME(S)</b> <i>Nombre de los Hermanos(as)</i> | <b>GRADE</b> <i>Grado</i> | <b>SIBLING NAME(S)</b> <i>Nombre de los Hermanos(as)</i> | <b>GRADE</b> <i>Grado</i> |
|----------------------------------------------------------|---------------------------|----------------------------------------------------------|---------------------------|
|                                                          |                           |                                                          |                           |
|                                                          |                           |                                                          |                           |

**Parent Signature** *Firma de los Padres*

**Date** *Fecha*

## For Parents - Vaccines Required to Attend School in Oklahoma 2016-17 School Year

This table shows the total number of doses a child must receive and have on their record to attend school for the grades indicated. The doses do not have to be repeated every year. These are the requirements for school. Requirements for child care attendance are different. Refer to this web page for the requirements for child care: [http://www.ok.gov/health/Disease\\_Prevention\\_Preparedness/Immunizations/Vaccines\\_for\\_Childcare/index.html](http://www.ok.gov/health/Disease_Prevention_Preparedness/Immunizations/Vaccines_for_Childcare/index.html).

|                                        | PRE-SCHOOL/<br>PRE-K | KG – 6th               | 7 <sup>th</sup> – 12 <sup>th</sup> |
|----------------------------------------|----------------------|------------------------|------------------------------------|
| <b>VACCINES</b>                        | <b>Total doses</b>   |                        |                                    |
| DTaP/ (diphtheria, tetanus, pertussis) | 4 DTaP               | 5 DTaP*                | 5 DTaP* & 1 Tdap <sup>♦</sup>      |
| IPV/OPV (inactivated polio/oral polio) | 3 IPV/OPV            | 4 IPV/OPV <sup>◀</sup> |                                    |
| MMR (measles, mumps, rubella)          | 1 MMR                | 2 MMR                  |                                    |
| HepB (hepatitis B)                     | 3 HepB <sup>■</sup>  |                        |                                    |
| HepA (hepatitis A)                     | 2 HepA               |                        |                                    |
| Varicella (chickenpox)                 | 1 Varicella          |                        |                                    |

|   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ★ | If the 4th dose of DTaP is given on or after the child's 4th birthday, then the 5th dose of DTP/DTaP is not required.                                                                                                                                                                                                                                                                                                                                                                                                        |
| ♦ | Tdap (tetanus, diphtheria, and pertussis) booster (Only 1 dose of Tdap is required.)                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| ◀ | If the 3rd dose of IPV/OPV is given on or after the child's 4th birthday, then the 4th dose of IPV/OPV is not required.                                                                                                                                                                                                                                                                                                                                                                                                      |
| ■ | If a child reaches age 11 and has not yet started the HepB vaccine series, he or she may receive a 2-dose series of Merck® Adult Hepatitis B vaccine instead of the 3-dose series of Pediatric HepB vaccine. The 2-dose series must be completed before the 16th birthday or the child must receive a total of 3 doses of HepB vaccine. If you have any questions about the 2-dose series of HepB vaccine, talk to your healthcare provider. All other children (younger or older) must have 3 doses of hepatitis B vaccine. |

### Vaccines Recommended for All Children but Not Required by Oklahoma School Law

A 2nd dose of varicella (chickenpox) vaccine is recommended at 4-6 years of age and at any age after that if it is missed at 4-6 years.

One dose of MCV4 (meningococcal vaccine) is recommended at age 11-12 years and a booster dose at 16 years of age.

- If an adolescent misses MCV4 at 11-12 years, they should still receive it. This vaccine is routinely recommended up to 18 years and through age 21 years for first year college students living in dormitories or on-campus student housing because of their risk of catching the disease.
- If an adolescent receives the first dose of MCV4 late at 13 through 15 years, they still need a booster dose at age 16 through 18 years.

Oklahoma law requires a dose of MCV4 for all students who are first-time enrollees in any public or private postsecondary educational institution in this state and who reside in on-campus student housing. It is recommended they receive a dose on or after the 16<sup>th</sup> birthday.

Three doses of HPV (human papillomavirus) vaccine are recommended for all pre-teens and teens starting at 11-12 years of age.

- If an adolescent misses HPV at 11-12 years catch-up vaccination is recommended for all girls 13-26 years and for all boys 13-21 years.

Keep a copy of your child's vaccination record, you may need it later.

## Vaccine-Preventable Diseases and the Vaccines that Prevent Them

### Diphtheria (Can be prevented by DTaP & Tdap vaccines)

Diphtheria is a very contagious bacterial disease that affects the respiratory system, including the lungs. Diphtheria bacteria can be passed from person to person by direct contact with droplets when an infected person coughs or sneezes. When people are infected, the diphtheria bacteria produce a toxin (poison) in the body that can cause weakness, sore throat, low-grade fever, and swollen glands in the neck. Effects from this toxin can also lead to swelling of the heart muscle and, in some cases, heart failure. **In severe cases, diphtheria can cause coma, paralysis, and even death.**

### Hepatitis A (Can be prevented by HepA vaccine)

Hepatitis A is an infection of the liver caused by hepatitis A virus. The virus is usually spread person-to-person through the fecal-oral route. In other words, the virus is taken in by mouth from contact with objects, food, or drinks contaminated by the feces (stool) of an infected person. Symptoms include fever, tiredness, loss of appetite, nausea, abdominal discomfort, dark urine, and jaundice (yellowing of the skin and eyes). An infected person may have no symptoms, may have mild illness for a week or two, or may have severe illness for several months that requires hospitalization. **In the U.S. about 100 people a year die from hepatitis A.**

### Hepatitis B (Can be prevented by HepB vaccine)

Hepatitis B is an infection of the liver caused by hepatitis B virus. The virus spreads through exposure to blood or other body fluids, for example, from sharing personal items, such as razors or during sex. Hepatitis B causes a flu-like illness with loss of appetite, nausea, vomiting, rashes, joint pain, and jaundice. **The virus stays in the liver of some people for the rest of their lives and can result in severe liver diseases, including fatal cancer.**

### Human Papillomavirus (Can be prevented by HPV vaccine)

Human Papillomavirus also known as HPV, is a very common virus that is spread by skin-to-skin contact during any type of sexual activity with another person. About 79 million Americans, most in their late teens and early 20s, are infected with HPV. HPV is so common that nearly all sexually active men and women get it at some point in their lives. It is a major cause of cervical cancer in women and genital warts in women and men. **Every year in the U.S. about 4,000 women die from cervical cancer caused by HPV and about 8,000 men get cancers caused by HPV.**

### Measles (Can be prevented by MMR vaccine)

Measles is one of the most contagious viral diseases. Measles virus is spread by direct contact with the airborne respiratory droplets of an infected person. Measles is so contagious that just being in the same room after a person who has measles has already left can result in infection. Symptoms usually include a rash, fever, cough, and red, watery eyes. Fever and rash can last for up to a week, and the coughing lasts about 10 days. **Measles can lead to pneumonia, seizures, brain damage, and death.**

### Meningococcal Disease (Can be prevented by MCV vaccine)

Meningococcal disease is caused by bacteria and is a leading cause of bacterial meningitis (infection around the brain and spinal cord) in children, teens and young adults. The bacteria are spread by droplets from the nose and throat through coughing, sneezing or kissing. Symptoms include nausea, vomiting, sensitivity to light, confusion and sleepiness. Meningococcal disease also causes blood infections. **About one of every ten people who get the disease dies from it. Survivors of meningococcal disease may lose their arms or legs, become deaf, have problems with their nervous systems, become developmentally disabled, or suffer seizures or strokes.**

### Mumps (Can be prevented by MMR vaccine)

Mumps is an infectious disease caused by the mumps virus, which is spread in the air by a cough or sneeze from an infected person. A child can also get infected with mumps by coming in contact with a contaminated object, like a toy. The mumps virus causes fever, headaches, painful swelling of the salivary glands under the jaw, muscle aches, tiredness, and loss of appetite. **Severe complications for children who get mumps are not common, but can include meningitis (infection of the covering of the brain and spinal cord), encephalitis (inflammation of the brain), permanent hearing loss, or swelling of the testes, which can lead to sterility in men, although this is rare.**

### Pertussis (Whooping Cough) (Can be prevented by DTaP & Tdap vaccines)

Pertussis is caused by bacteria spread through direct contact with respiratory droplets when an infected person coughs or sneezes. In the beginning, symptoms of pertussis are similar to the common cold, including runny nose, sneezing, and cough. After 1-2 weeks, pertussis can cause spells of violent coughing and choking, making it hard to breathe, drink, or eat. This cough can last for weeks. **Pertussis is most serious**

**for babies, who can get pneumonia, have seizures, become brain damaged, or even die.** About two-thirds of children under 1 year of age who get pertussis must be hospitalized.

### Polio (Can be prevented by IPV vaccine)

Polio is caused by a virus that lives in an infected person's throat and intestines. It spreads through contact with the feces (stool) of an infected person and through droplets from a sneeze or cough. Symptoms typically include sudden fever, sore throat, headache, muscle weakness, and pain. In about 1% of cases, polio can cause paralysis. **Among those who are paralyzed, up to 5% of children die because they become unable to breathe.**

### Rubella (German Measles) (Can be prevented by MMR vaccine)

Rubella is caused by a virus that is spread through coughing and sneezing. In children rubella usually causes a mild illness with fever, swollen glands, and a rash that lasts about 3 days. Rubella rarely causes serious illness or complications in children, but can be very serious to a baby in the womb. **If a pregnant woman is infected, the result to the baby can be devastating, including miscarriage and serious birth defects.**

### Tetanus (Lockjaw) (Can be prevented by Tdap vaccine)

Tetanus is caused by bacteria found in soil. The bacteria enter the body through a wound, such as a deep cut. When people are infected, the bacteria produce a toxin (poison) in the body that causes serious, painful spasms and stiffness of all muscles in the body. This can lead to "locking" of the jaw so a person cannot open his or her mouth, swallow, or breathe. **Complete recovery from tetanus can take months. Three of ten people who get tetanus die from the disease.**

### Varicella (Chickenpox) (Can be prevented by varicella vaccine)

Chickenpox is caused by the varicella zoster virus. Chickenpox is very contagious and spreads very easily from infected people. The virus can spread from either a cough or a sneeze. It can also spread from the blisters on the skin, either by touching them or by breathing in the viral particles. Typical symptoms of chickenpox include an itchy rash with blisters, tiredness, headache and fever. **Chickenpox is usually mild, but it can lead to severe skin infections, pneumonia, encephalitis (brain swelling), and even death.**