Charlie Keyan Armenian Community School
Չարլի Քէյեան Համագաղութային Հայ Վարժարան

EARLY REGISTRATION

Dear Parents,

We wish to welcome you to the 2017 – 2018 school year at the Charlie Keyan Community School. The school year begins on Monday, August 21, 2017.

INFORMATION REGARDING REGISTRATION

* You are receiving registration forms for each child along with the tuition schedule.
* Forms must be completed by the parents in order to be processed.
* Your child will only be admitted to school with a current signed and completed Registration form and Physicians signed form.
* Immunization records must be current for registration.
* First Grade health check-up is necessary for children entering the first grade.
* **Summer office hours are 8:15 a.m. – 3:15 M-F.**

We are looking forward to a successful academic year. Your early registration will facilitate any necessary preparations that can be accomplished during the summer months.

Thank you for your cooperation.

Respectfully,

School Board

www.ckacs.org 108 N. Villa Ave. Clovis, CA 93612 tel: 559.323.1955 fax: 559.323.1959 email: info@ckacs.org

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REGISTRATION FORM FOR 2017-2018 SCHOOL YEAR
STUDENT INFORMATION

DATE OF REGISTRATION_____

STUDENT'S NAME_____

STUDENT'S BIRTH DATE_____ COUNTRY OF BIRTH_____

CITY OF BIRTH_____

MALE _____ FEMALE_____ GRADE LEVEL_____

PREVIOUS SCHOOL ATTENDED_____

HOME ADDRESS_____ CITY_____STATE_____ ZIP_____

HOME PHONE_____MESSAGE PHONE_____

FATHER'S NAME_____FATHER'S EMAIL_____

FATHER'S OCCUPATION_____FATHER'S WORK #_____

FATHER'S CELL# _____

MOTHER'S NAME_____MOTHER'S EMAIL _____

MOTHER'S OCCUPATION_____MOTHER'S WORK #_____

MOTHER'S CELL#_____

IN CASE OF EMERGENCY

NAME OF FRIEND OR RELATIVE_____

PHONE NUMBER OF RELATIVE (1)_____(2)_____

STUDENTS PHYSICIAN'S NAME & ADDRESS _____

_____

PHYSICIAN'S PHONE NUMBER_____

INFORMATION STATEMENT

SCHOOL HOURS

* Pre-K (until noon)	8:15 a.m. – 12:00 noon
* Pre-K Full Day	8:15 a.m. – 3:15 p.m.
* Grades K through Sixth	8:15 a.m. – 3:15 p.m.

TUITION FOR 2017 - 2018

* Elementary Tuition--(K-6)	$ 4,620.00 annually
* Pre-K five day all day	$ 4,944.00 annually
* Pre-K, three day all day	$ 4,532.00 annually
* Pre-K, half day till noon Mon-Fri	$ 4,532.00 annually
* Pre-K half day three days	$ 3,656.00 annually

TUITION DISCOUNTS:

- 10% for the second child from the same family
- 15% for the third child from the same family
- 20% for the fourth child from the same family
- 25% for the fifth child from the same family

ANNUAL TUITION:

- If you will be making monthly tuition payments, a deposit of $250.00 is required. It is non-refundable and will be applied towards tuition.
- Uniforms are required for all grade levels. Boys – White shirt/Navy pants
  Girls – White blouses with plaid skirts, (shorts should be worn under skirts) jumper or box pleats which are available at **Dennis School Uniform Co.- 5186 N Blythe Ave # 101, Fresno, CA 93722.**
- If you would like to request financial aid (kindergarten through sixth grade). The financial aid forms are available in the office and online on the school website: www.ckacs.org.
- **Financial aid applications must be turned in by July 1, 2017**
- The financial aid committee will review your documentation and contact you to schedule an appointment, if necessary.
- **FINANCIAL AID IS NOT AVAILABLE FOR PRE -K**

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Tuition Payment Agreement

Student Names: Immunization Records Current?

1. _____ Grade____ Tuition $_____ Yes or No
2. _____ Grade____ Tuition $_____ Yes or No
3. _____ Grade____ Tuition $_____ Yes or No
4. _____ Grade____ Tuition $_____ Yes or No
5. _____ Grade____ Tuition $_____ Yes or No
6. _____ Grade____ Tuition $_____ Yes or No

Total $_____

DISCOUNTS
Multiple Students Discount

2nd student – 10% $<_____>
3rd student – 15% $<_____>
4th student – 20% $<_____>
5th + student– 25% $<_____>

Financial Aid **$ <_____>**

Scholarship **$ <_____>**

Total discount **$ <_____>**

Subtotal **$ _____**

None Refundable Registration Fee per student $250.00 **$ _____**

TOTAL DUE EACH MONTH **$ _____ X 10**

ANNUAL TOTAL DUE **$ _____**

Credit Card surcharge 2% **$ _____ Total Due$_____**

I further understand and agree that:

1. This Agreement may not be modified by any oral statements made by a representative of CKACS or by me;
2. Unless agreed to in writing by the school's Board of Education or its authorized representative, there are no other written terms or conditions modifying this Agreement; and
3. I may not assign this Agreement, or delegate any of my obligations under this Agreement, without the written consent of the school's Board of Education or its authorized representative.
4. If I'm more than 10 days late with any payment, I will also owe a late fee of $25.
5. Tuition fees must be fully paid prior to the beginning of the school year so that your child may return in the fall.
6. I agree to comply with the Parent Participation Hours (PPH) Program.
   I agree to: a) Full time provide (or arrange for a family member to provide on my behalf) at least 30 hours of assistance to the school by June 1 of the new school year.
   b) Part time provide (or arrange for a family member to provide on my behalf) at least 15 hours of assistance to the school by June 1 of the new school year.
   b) Log my time in the PPH binder in the school office.
   c) Pay $20 by June 15 for each hour short of 30 hours logged in the PPH binder as of June1; and
   d) Comply with terms of the PPH program.

I acknowledge that I have read and that I understand the foregoing payment plan, and that I agree with its terms and conditions.

The administration, staff and Board of Education of the Charlie Keyan Armenian School will provide the highest quality of education to all students. The parents promise to do all that is required of them to assist in the education of their children.

I/We have read the foregoing Tuition Payment Agreement and agree that it shall be binding upon me/us.

Signature: _____ Date: _____
Name of Parent/ Guardian

Signature: _____ Date: _____
Name of Parent/ Guardian

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS NUMBER STREET	CITY	STATE ZIP		BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE ZIP		HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER STREET	CITY	STATE ZIP		HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE | DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION | DATE LEFT

PARENT / GUARDIAN INFORMATION

Parent/Guardian 1: Last: _____ First: _____ MI: __

Street Address: _____ City: _____ Zip Code: _____

Home Phone Number: _____ Work Location: _____

Work Number: _____ Cell Number: _____

E-mail: _____ Preferred Number to Call: _____

Parent/Guardian 2: Last: _____ First: _____ MI: __

Street Address: _____ City: _____ Zip Code: _____

Home Phone Number: _____ Work Location: _____

Work Number: _____ Cell Number: _____

E-mail: _____ Preferred Number to Call: _____

Child(ren) Lives with: Both Parents_ Parent 1 _Parent 2_ Joint Custody_ Other_

CHILDREN'S INFORMATION

Last: _____ First: _____ Nickname: _____

Birthdate: _____ Age: _____ Entrance Date: _____

Days Attending: _____

OTHE SIBLINGS

Last: _____ First: _____ Nickname: _____

Birthdate: _____ Age: _____

Last: _____ First: _____ Nickname: _____

Birthdate: _____ Age: _____

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH _____
DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____ . This Child Care Center/School provides a program which extends from _____ : ____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m. , _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature _____

☑ Physician ☑ Physician's Assistant ☑ Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

* Have a family member or contacts with a history of confirmed or suspected TB.
* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
* Live in out-of-home placements.
* Have, or are suspected to have, HIV infection.
* Live with an adult with HIV seropositivity.
* Live with an adult who has been incarcerated in the last five years.
* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
* Have abnormalities on chest X-ray suggestive of TB.
* Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: COMMUNITY CARE LICENSING

   Licensing Office Address: 770 EAST SHAW # 300

   Licensing Office Telephone #: (559) 243-4588

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: ***CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.***

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

LIC 995 (9/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

_____
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

NOTE: ***This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.***

For the Department of Justice "Registered Sex Offender"database go to www.meganslaw.ca.gov

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

ADDRESS

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

HOLD HARMLESS FORM

If an accident occurs at The Learning Center, I will not hold them responsible financially unless the accident occurred because of structural neglect and carelessness.

Child Name: _____

_____ _____

Parent's Signature Date

FIELD TRIP RELEASE FORM

I hereby give permission for my child _____ to attend ALL walking field trips. This may include but this is not limited to; a walk to the park, nearby school, public library, grocery store. During the Summer this would include a walk to the High School pool for the school age children only. I understand that this will be considered current during my child's enrollment at The Learning Center.

_____ _____

Parent's Signature Date

PHOTO RELEASE FORM

I herby give my permission for my child _____ to be photographed while doing activities at The Learning Center. These photos will be used ONLY for school purposes.

_____ _____

Parent's Signature Date

2016 Recommended Immunizations for Children from Birth Through 6 Years Old

Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
HepB	HepB			HepB						
		RV	RV	RV						
		DTaP	DTaP	DTaP		DTaP				DTaP
		Hib	Hib	Hib	Hib					
		PCV	PCV	PCV	PCV					
		IPV	IPV			IPV				IPV
						Influenza (Yearly)*				
					MMR					MMR
					Varicella					Varicella
					HepA§					

Is your family growing? To protect your new baby and yourself against whooping cough, get a Tdap vaccine in the third trimester of each pregnancy. Talk to your doctor for more details.

Shaded boxes indicate the vaccine can be given during shown age range.

NOTE: If your child misses a shot, you don't need to start over, just go back to your child's doctor for the next shot. Talk with your child's doctor if you have questions about vaccines.

FOOTNOTES:

* Two doses given at least four weeks apart are recommended for children aged 6 months through 8 years of age who are getting an influenza (flu) vaccine for the first time and for some other children in this age group.

§ Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 to 18 months later. HepA vaccination may be given to any child 12 months and older to protect against HepA. Children and adolescents who did not receive the HepA vaccine and are at high-risk, should be vaccinated against HepA.

If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your child's doctor about additional vaccines that he may need.

For more information, call toll free
1-800-CDC-INFO (1-800-232-4636)
or visit
http://www.cdc.gov/vaccines

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™