

## Healthcare Provider's Certification of In Process Required School Immunizations

Connecticut Immunization school entry requirements require that students whose initial immunizations have been given but additional required immunizations are in process to submit this certification from the student's physician, physician assistant (PA) or advance practice registered nurse (APRN) that the additional immunizations are in process in accord with guidelines and schedule specified by the Commissioner of Public Health ([Connecticut Department of Public Health Schedule For In Process Required School Immunizations](#)). Physicians, PAs, and APRNs must follow the CDC catch up schedule following the minimum spacing interval between doses and complete the administration of the additional required immunizations no later than 30-days after the minimal interval time period has occurred.

**I certify that the student identified below is my patient and that I will provide any required school immunizations for the student's school enrollment which have not been administered as of this date in accord with the Connecticut Commissioner of Public Health Schedule For In Process Required School Immunizations.**

Name of Primary Care Provider: \_\_\_\_\_

Please check one (provider granting exemption must be licensed as one of the following):

- Physician (M.D. or D.O.)     Physician Assistant     APRN

Connecticut License number: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Patient/Student Information:

First name (in full) \_\_\_\_\_ Middle initial \_\_\_\_\_ Last name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian: First Name \_\_\_\_\_ Last name \_\_\_\_\_

Primary phone number \_\_\_\_\_

School name \_\_\_\_\_

School address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Current Grade student is entering \_\_\_\_\_