



Children and Parents  
Learning Together

## **Registration Packet Checklist for Benson Hill Cooperative Preschool**

Please bring the following completed forms to our All School Orientation Meeting. If you have any questions please email us at [Registration@bensonhillcoop.org](mailto:Registration@bensonhillcoop.org), or call us at (253) 833-9111 ext. 4829.

1. Participation Agreement / Risk Management / Permission to Photograph (one sheet)
2. Field Trip form (for Three's and Pre-k classes only)
3. Medical Consent Form (2 copies for Three's and Pre-k classes, 1 copy for all others)
4. Child Release / Emergency contact form
5. Instructions for applying online to Green River Community College (new families only)
6. GRCC Insurance form (copy of driver's license and Insurance coverage)
7. Immunization form
8. Tuition for September and May, plus \$2 for an optional school bag.

Child's name \_\_\_\_\_ Class \_\_\_\_\_

### **Participation Agreement**

We ensure the success of our program by participating in the following ways:

- Work in the classroom on a rotating basis approximately once a week as assigned by the Parent Coordinator. This varies depending on the class and enrollment levels.
- Hold and complete a Class, Board or "All School" job.
- Attend required monthly parent meetings and all school functions. Parent meetings for the Three's and Pre-K classes are in the evenings.
- Fulfill all tuition requirements. BHCP tuition is due by the 5th of every month.
- Pay GRCC tuition online quarterly.
- Bring snacks on rotating basis.
- Participate in fundraising events or meet fundraising obligation. The annual fundraising requirement is a minimum of \$100 per child or \$150 per family.
- Participate in two Classroom Cleaning Nights during the school year.
- Read and abide by all preschool regulations in the Parent Handbook.
- Should you choose to withdraw from BHCP, obtain a *Notice of Intent to Drop* form from your Class Treasurer, complete it, and return it to them with a minimum of two weeks' notice.

**Please initial to indicate you have read and agree to meet the above requirements**

### **Risk Management**

I have watched the Risk Management Video (video will be shown at orientation or can be watched through a link on our website) which reviews health and safety procedures in the following areas:

- Parent/Child Arrival and Departure
- Adult Safety Responsibilities in the Classroom
- Indoor / outdoor Safety
- Disease Control and Hand washing
- Food Preparation and Clean-up
- First Aid and Medical Emergencies
- Fire and Earthquake Procedures
- Health and Safety Bulletin Boards
- Field Trips
- Child Abuse and Neglect Policies

**I agree to abide by these policies, requirements and procedures when I attend class at Benson Hill Cooperative Preschool. Initial here: \_\_\_\_\_**

### **Permission to Photograph**

I give permission for my child to be photographed in scheduled preschool activities. Such photographs may be used by the Cooperative for publicity or educational purposes. At no time will the photos be used with identifying information beyond first name and age/class level in a public form.

**I agree (initials) \_\_\_\_\_**

**I do not agree (initials) \_\_\_\_\_**

Child's name \_\_\_\_\_ Class \_\_\_\_\_

**Field Trip Driver Information**

*This form must be completed by all drivers/owners of vehicles used to transport students to or from activities sponsored by the co-ops. (If you will not be driving on field trips, please sign at the bottom)*

Transporting children involves special responsibilities. The following are safety considerations by which we must abide:

1. All parents who drive children other than their own must have a valid Washington State driver's license and liability insurance.
2. Drivers must not be using medication that could affect their driving nor be under the influence of any drug or alcohol.
3. Each child must have his or her own seat in the car. Each person in the car needs to use a proper seat restraint
4. At least one adult must be in the car who is responsible for the children only. Drivers will be responsible for driving only.
5. Children shall never be left in a vehicle without adult supervision.
6. Keep doors locked and windows up.

*I am willing and able to drive. I have read and agree to abide by the safety recommendations outlined above. I have a valid Washington State driver's license and liability insurance (minimum required by the Financial Responsibility Law of the State of Washington: 15/30/10 Bodily injury and property Damage) which will enable me to drive on field trips.*

*As a volunteer driver I understand that the liability insurance on my vehicle is primary insurance and in the event of an accident, my insurance will respond to any injury or damage. To the extent that I am legally obligated to pay, I also agree to hold harmless the parent education cooperative, its board members, employees and staff from any and all claims, liabilities, damages or expenses (including defense costs) arising directly or indirectly from the maintenance, ownership or use of my vehicle.*

\_\_\_\_\_  
Parent/driver's signature Date

Name of Co-op \_\_\_\_\_

**Insurance Information**

Name of Auto Insurance carrier \_\_\_\_\_

Policy Number \_\_\_\_\_ Term of coverage \_\_\_\_\_

|                    |                   |          |                       |
|--------------------|-------------------|----------|-----------------------|
| Limit of Insurance | (Bodily injury)   | \$ _____ | per person            |
|                    |                   | \$ _____ | per accident          |
|                    | (Property damage) | \$ _____ | per accident          |
|                    | Or:               | \$ _____ | combined single limit |

*I am unable to drive on field trips but support the safety recommendations outlined above.*

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

Child's name \_\_\_\_\_ Class \_\_\_\_\_

**Benson Hill Co-op Medical Consent form**

In case of emergency, Benson Hill Cooperative Preschool, has my consent to authorize medical care for my child \_\_\_\_\_

Physicians name: \_\_\_\_\_

Physicians telephone \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_

Member's Name \_\_\_\_\_

Identification number \_\_\_\_\_

Benefit Code \_\_\_\_\_

Account Number \_\_\_\_\_

Contact me immediately at: \_\_\_\_\_

If unable to contact me, please call:

\_\_\_\_\_ @ \_\_\_\_\_

Allergies \_\_\_\_\_

Medication your child might be taking \_\_\_\_\_

***Signed by***

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

Printed name: \_\_\_\_\_

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

Child's name \_\_\_\_\_ Class \_\_\_\_\_

**Benson Hill Co-op Medical Consent form**

In case of emergency, Benson Hill Cooperative Preschool, has my consent to authorize medical care for my child \_\_\_\_\_

Physicians name: \_\_\_\_\_

Physicians telephone \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_

Member's Name \_\_\_\_\_

Identification number \_\_\_\_\_

Benefit Code \_\_\_\_\_

Account Number \_\_\_\_\_

Contact me immediately at: \_\_\_\_\_

If unable to contact me, please call:

\_\_\_\_\_ @ \_\_\_\_\_

Allergies \_\_\_\_\_

Medication your child might be taking \_\_\_\_\_

***Signed by***

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

Printed name: \_\_\_\_\_

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

Child's name \_\_\_\_\_ Class \_\_\_\_\_

### Child Release Form for Regularly Authorized Adults

I \_\_\_\_\_ authorize the release of my child \_\_\_\_\_ to the following adult (s) during the regular school year. The authorized adult will be **required** to show **picture ID**.

| Name | Relationship | Cell number during class time | Phone Number |
|------|--------------|-------------------------------|--------------|
|      |              |                               |              |
|      |              |                               |              |
|      |              |                               |              |

Signature of Parent or Guardian \_\_\_\_\_  
Date \_\_\_\_\_

**Note:** Children who are to be taken home by someone other than their parent or an adult on the Authorized list must have written permission and picture ID prior to being released. The child will remain at school until the designated person arrives.

### Emergency Contact Numbers

Please provide names and numbers of an emergency contact. Provide an out of state contact if possible. These numbers will be kept confidential and only used if we need to urgently contact you and cannot do so with the numbers provided on your registration form.

| Name | Relationship | Cell number | Phone number |
|------|--------------|-------------|--------------|
|      |              |             |              |
|      |              |             |              |
|      |              |             |              |

## **Instructions for Applying Online to Green River Community College**

As a parent at Benson Hill cooperative Preschool, you are also a student at Green River Community College (GRCC). Your classroom is our preschool and your instructor is your parent educator. In order to register for this “class”, you must complete a two part process. The first part-applying for admission as described below-you will do only once. If your child continues at BHCP in subsequent years or if you have other children that later join BHCP, you will NOT have to repeat this application process. The second part is registering for the class, which will be explained later by your parent educator, and is done every quarter.

Here are the instructions for applying for admission to GRCC: (Please have this done by the All-School Orientation.)

1. Go to [www.greenriver.edu](http://www.greenriver.edu)
2. click on Online Services
3. Pull down menu and choose Apply for Admission
4. Scroll down and click on Web Admissions Center
5. Begin with option 1, then proceed to option 2 and 3

**You will be given a student ID number. Please write this down and don't lose it!** You will use this to register for the parent education class later.

Please note: **You, the parent are the student at GRCC, not your child.** If you have more than one child in this class, it is only necessary to have one parent register.

If you have any questions, or do not have access to a computer, please contact us at (253)833-9111 ext. 4829

## **GRCC Insurance Coverage through OPEP**

Green River Community College (GRCC) obtains coverage for the co-op preschools from the Organization of Parent Education Programs (OPEP). OPEP is secondary coverage, and in providing this coverage, they ask all co-op families to provide copies of their driver's license and insurance. This secondary coverage protects you (and others in your vehicle) when you are driving to and from preschool and to other preschool events.

Please bring a copy of your driver's license and a copy of your current proof of car insurance coverage in a sealed envelope, with your child's name and class on the outside, to your Parent Only Meeting. Please give the envelope to your Class Chair or Teacher. We (BHCP) will keep this confidentially on file.

If you choose not to provide the above information, please bring a letter stating this and give it to your Class Chair or Teacher. Below is a sample wording for this letter. Please be sure it is signed and dated.

*I am choosing not to be in compliance with the recommended risk management policies that are put in place by OPEP. By not providing the requested information, I am taking responsibility for transporting only my child to and from all preschool activities.*

Signed \_\_\_\_\_ Date \_\_\_\_\_

# Certificate of Exemption

## For School, Child Care and Preschool Immunization Requirements<sup>1</sup>



**DIRECTIONS:** All exemptions must have a licensed health care provider sign & date Box 1 ('Provider Statement').<sup>2</sup> Exception: Box 1 is not required for religious exemptions when Box 2 ('Demonstration of Religious Membership') is completed. All exemptions must also have a parent/guardian sign & date Box 3 ('Parent/Guardian Statement').

|                           |                    |                        |                                |             |   |
|---------------------------|--------------------|------------------------|--------------------------------|-------------|---|
| <b>Child's Last Name:</b> | <b>First Name:</b> | <b>Middle Initial:</b> | <b>Birthdate (mm/dd/yyyy):</b> | <b>Sex:</b> | <b>Parent/Guardian Name (please print):</b> |
|---------------------------|--------------------|------------------------|--------------------------------|-------------|---|

**Parent/Guardian, please choose the exemption(s) that apply to your child below.**

|   |   |
|---|---|
| <input type="checkbox"/> <b>Temporary Medical Exemption</b><br><input type="checkbox"/> <b>Permanent Medical Exemption</b><br><hr/> Vaccine(s) _____ Until _____<br>Date (or Permanent)<br><hr/> Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)<br><hr/> X _____ X _____<br>Signature of Licensed Health Care Provider Date | <input type="checkbox"/> <b>Personal/Philosophical Exemption (see Box 1)</b><br><input type="checkbox"/> <b>Religious Exemption (see Box 1)</b><br><input type="checkbox"/> <b>Religious Membership Exemption (see Box 2)</b><br>I do not want my child to get the following vaccine(s):<br><input type="checkbox"/> Diphtheria <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hib<br><input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Pertussis (whooping cough)<br><input type="checkbox"/> Pneumococcal <input type="checkbox"/> Polio <input type="checkbox"/> Rubella<br><input type="checkbox"/> Tetanus <input type="checkbox"/> Varicella (chickenpox)<br><input type="checkbox"/> Other (indicate): _____ |
|---|---|

| Box 1  |
|--|
| <p><b>Provider Statement<sup>2</sup>:</b> "I, _____, am a qualified provider (MD, DO, ND, PA, ARNP) licensed under Title 18 RCW. I confirm that the parent or guardian signing in Box 3 (Parent/Guardian Statement) has received information on the benefits and risks of immunization to their child as a condition for exempting their child for medical, religious, personal, or philosophical reasons."<br/>                 X _____<br/>                 Signature of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)<br/>                 X _____<br/>                 Date</p> |

| Box 2  |
|--|
| <p><b>Parent/Guardian Demonstration of Religious Membership:</b> "I am a member of a church or religious body whose beliefs or teachings do not allow for medical treatment from a health care practitioner. By supplying the information requested below, no further proof or signed provider statement in Box 1 is required for this religious exemption."<br/>                 X _____<br/>                 Name of Church or Religious Body<br/>                 X _____ X _____<br/>                 Signature of Parent or Guardian Date</p> |

| Box 3  |
|--|
| <p><b>Parent/Guardian Statement:</b> "I certify that all the information provided on this certificate is correct and verifiable. I understand that if there is an outbreak of a vaccine-preventable disease my child has not been fully immunized against (as indicated above, for medical, personal/philosophical or religious reasons), my child may be at risk for disease and can be <b>excluded</b> from school, child care, or preschool until the outbreak is over."<br/>                 X _____ X _____<br/>                 Signature of Parent or Guardian Date</p> |

If you have a disability and need this document in a different format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

<sup>1</sup> RCW 28A.210.080-090 states that before or on the first day of every child's attendance at any public and private school or licensed child care center in Washington State, the parent or guardian must present proof of either: (1) full immunization, (2) the initiation of and compliance with a schedule of immunization, as required by rules of the State Board of Health, or (3) a certificate of exemption, signed by a parent or guardian and a licensed health care provider.

<sup>2</sup> A letter may substitute for a signed 'Provider Statement' on this certificate. To be accepted, the letter must reference the child's name on this certificate, confirm that the child's parent or guardian got information on the risks and benefits of immunization to their child, and be signed by a licensed health care provider.



# Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

|   |             |
|---|-------------|
| <b>Office Use Only:</b>   |             |
| Reviewed by: _____  | Date: _____ |
| Signed Cert. of Exemption on file? <input type="checkbox"/> Yes <input type="checkbox"/> No |             |

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

|  |                          |                              |                                      |   |  |
|--|--------------------------|------------------------------|--------------------------------------|---|--|
| <b>Child's Last Name:</b> _____  | <b>First Name:</b> _____ | <b>Middle Initial:</b> _____ | <b>Birthdate (mm/dd/yyyy):</b> _____ | <b>Sex:</b> _____                                 | <b>I certify that the information provided on this form is correct and verifiable.</b> |
| Symbols below:<br>◆ Required for School and Child Care/Preschool<br>● Required for Child Care/Preschool Only |                          |                              |                                      | <b>Parent/Guardian Name (please print):</b> _____ |  |

| Vaccine   | Dose | Date  |     |      |
|---|------|-------|-----|------|
|   |      | Month | Day | Year |
| <b>◆ Hepatitis B (Hep B)</b>                            |      |       |     |      |
|   | 1    |       |     |      |
|   | 2    |       |     |      |
|   | 3    |       |     |      |
| or Hep B - 2 dose alternate schedule for teens          |      |       |     |      |
|   | 1    |       |     |      |
|   | 2    |       |     |      |
| <b>Rotavirus (RV1, RV5)</b>                             |      |       |     |      |
|   | 1    |       |     |      |
|   | 2    |       |     |      |
|   | 3    |       |     |      |
| <b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b> |      |       |     |      |
|   | 1    |       |     |      |
|   | 2    |       |     |      |
|   | 3    |       |     |      |
|   | 4    |       |     |      |
|   | 5    |       |     |      |
| <b>◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)</b>      |      |       |     |      |
|   | 1    |       |     |      |
|   | 2    |       |     |      |
| <b>● Haemophilus influenzae type b (Hib)</b>            |      |       |     |      |
|   | 1    |       |     |      |
|   | 2    |       |     |      |
|   | 3    |       |     |      |
|   | 4    |       |     |      |
| <b>● Pneumococcal (PCV, PPSV)</b>                       |      |       |     |      |
|   | 1    |       |     |      |
|   | 2    |       |     |      |
|   | 3    |       |     |      |
|   | 4    |       |     |      |

| Vaccine  | Dose | Date       |     |                          |  |
|--|------|------------|-----|--------------------------|--|
|  |      | Month      | Day | Year                     |  |
| <b>◆ Polio (IPV, OPV)</b>  |      |            |     |                          |  |
|  | 1    |            |     |                          |  |
|  | 2    |            |     |                          |  |
|  | 3    |            |     |                          |  |
|  | 4    |            |     |                          |  |
| <b>Influenza (flu, most recent)</b>  |      |            |     |                          |  |
|  |      |            |     |                          |  |
|  |      |            |     |                          |  |
| <b>◆ Measles, Mumps, Rubella (MMR)</b>   |      |            |     |                          |  |
|  | 1    |            |     |                          |  |
|  | 2    |            |     |                          |  |
| <b>◆ Varicella (chickenpox) or verify disease 1-4 ▶</b>  |      |            |     |                          |  |
|  | 1    |            |     |                          |  |
|  | 2    |            |     |                          |  |
| <b>Hepatitis A (Hep A)</b>   |      |            |     |                          |  |
|  | 1    |            |     |                          |  |
|  | 2    |            |     |                          |  |
| <b>Meningococcal (MCV, MPSV)</b>   |      |            |     |                          |  |
|  | 1    |            |     |                          |  |
| <b>Human Papillomavirus (HPV)</b>  |      |            |     |                          |  |
|  | 1    |            |     |                          |  |
|  | 2    |            |     |                          |  |
|  | 3    |            |     |                          |  |
| <b>Office Use Only: Immunization information updated and verified with parent/guardian permission:</b> |      |            |     |                          |  |
| Printed Staff Name _____   |      | Date _____ |     | Printed Staff Name _____ |  |
| Printed Staff Name _____   |      | Date _____ |     | Printed Staff Name _____ |  |
| Printed Staff Name _____   |      | Date _____ |     | Printed Staff Name _____ |  |
| Printed Staff Name _____   |      | Date _____ |     | Printed Staff Name _____ |  |

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. **Mark option 1, 2, 3, OR 4 below – see, back #5.**

**1)  Chickenpox disease verified by printout from CHILD Profile Immunization Registry**  
Must be marked by printout (not by hand) to be valid.

**2)  Chickenpox disease verified by Health Care Provider (HCP)**  
If you choose this box, mark 2A OR 2B below.  
 2A)  Signed note from HCP attached OR  
 2B)  HCP signed here and print name below:  
 \_\_\_\_\_  
 Licensed health care provider (HCP) Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (MD, DO, ND, PA, ARNP)  
 HCP Printed Name: \_\_\_\_\_

**3)  Chickenpox disease verified by school staff from CHILD Profile Immunization Registry**  
If you choose this box, staff must initial that parent or guardian approves: \_\_\_\_\_ (initial) \_\_\_\_\_ (date)

**4)  Chickenpox disease verified by parent\***  
If you choose this box, fill in the date or child's age when he or she had the disease:  
 Age/Date of disease: \_\_\_\_\_  
 \*Can ONLY verify for some grades, see back #5 (4).

**If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.**

**Documentation of Disease Immunity**

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked. Signed lab report(s) MUST also be attached.

|                                      |                                    |                                       |
|--------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Diphtheria  | <input type="checkbox"/> Mumps     | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Polio     | _____                                 |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rubella   | _____                                 |
| <input type="checkbox"/> Hib         | <input type="checkbox"/> Tetanus   | _____                                 |
| <input type="checkbox"/> Measles     | <input type="checkbox"/> Varicella | _____                                 |

Licensed health care provider (HCP) Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (MD, DO, ND, PA, ARNP)  
 HCP Printed Name: \_\_\_\_\_

**Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Registry or filling it in by hand.**

**#1 To print with info filled in:** First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS** in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

**EXAMPLE**

**#2 To fill in by hand:** Print your child's name, birthdate, sex, and your own name in the top box.

**#3** Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

| Vaccine   | Dose     | Date  |     |      |
|---|----------|-------|-----|------|
|   |          | Month | Day | Year |
| <b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b> |          |       |     |      |
| DTaP  | <b>1</b> | 01    | 12  | 2011 |
| DTaP  | <b>2</b> | 03    | 20  | 2011 |
| DTaP  | <b>3</b> | 06    | 01  | 2011 |

**#4** If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

**#5** If your child has had chickenpox (varicella) disease and not the vaccine, **use only one** of these four options to record this on the CIS:

- 1)  If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
- 2)  If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
- 3)  If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
- 4)  If your child started kindergarten in the 2008-2009 school year or later, you **CANNOT** use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: <http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm>

**#6** Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

**#7** Be sure to **sign and date the CIS** in the upper right hand box, and return to school or child care.

**#8** If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

| Vaccine Trade Names in alphabetical order |             |           |            |                  |                    |                   |                      |                 |               |
|---|-------------|-----------|------------|------------------|--------------------|-------------------|----------------------|-----------------|---------------|
| ActHIB                                    | Hib         | Engerix-B | Hep B      | Ipol             | IPV                | Pentavalente      | DTaP + Hep B + Hib   | TriHIBit        | DTaP + Hib    |
| Adacel                                    | Tdap        | Fluarix   | Flu (TIV)  | Infanrix         | DTaP               | Pneumovax         | PPSV or PPV23        | Tripedia        | DTaP          |
| Afluria                                   | Flu (TIV)   | FluLaval  | Flu (TIV)  | Kinrix (Knrx)    | DTaP + IPV         | Prevnar           | PCV or PCV7 or PCV13 | Twinrix (Twnrx) | Hep A + Hep B |
| Boostrix                                  | Tdap        | FluMist   | Flu (LAIV) | Menaetra         | MCV or MCV4        | ProQuad (PrQd)    | MMR + Varicella      | Vaqa            | Hep A         |
| Cervarix                                  | HPV2        | Fluvirin  | Flu (TIV)  | Menomune         | MPSV or MPSV4      | Quadracel (Qdrel) | DTaP + IPV           | Varivax         | Varicella     |
| Comvax (Cmvx)                             | Hep B + Hib | Fluzone   | Flu (TIV)  | Pediarix (Pdrx)  | DTaP + Hep B + IPV | Recombivax HB     | Hep B                |                 |               |
| Daptacel                                  | DTaP        | Gardasil  | HPV4       | PedvaxHIB        | Hib                | Rotarix           | Rotavirus (RV1)      |                 |               |
| Decavac                                   | Td          | Havrix    | Hep A      | Pentacel (Pntcl) | DTaP + Hib + IPV   | RotaTeq           | Rotavirus (RV5)      |                 |               |

| Vaccine Abbreviations in alphabetical order |  |             |                                      |                      |  |                   |  |
|---|--|-------------|--------------------------------------|----------------------|--|-------------------|--|
| DT  | Diphtheria, Tetanus                      | Hep A (HAV) | Hepatitis A                          | MPSV or MPSV4        | Meningococcal Polysaccharide Vaccine     | Rota (RV1 or RV5) | Rotavirus                                |
| DTaP  | Diphtheria, Tetanus, acellular Pertussis | Hep B (HBV) | Hepatitis B                          | MMR / MMRV           | Measles, Mumps, Rubella / with Varicella | Td                | Tetanus, Diphtheria                      |
| DTP   | Diphtheria, Tetanus, Pertussis           | Hib         | <i>Haemophilus influenzae</i> type b | OPV                  | Oral Poliovirus Vaccine                  | Tdap              | Tetanus, Diphtheria, acellular Pertussis |
| Flu (TIV or LAIV)                           | Influenza                                | HPV         | Human Papillomavirus                 | PCV or PCV7 or PCV13 | Pneumococcal Conjugate Vaccine           | TIG               | Tetanus immune globulin                  |
| HBIG  | Hepatitis B Immune Globulin              | IPV         | Inactivated Poliovirus Vaccine       | PPSV or PPV23        | Pneumococcal Polysaccharide Vaccine      | VAR or VZV        | Varicella                                |

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