****U**2025 IMMUNIZATION REQUIREMENTS**

All campers must be fully immunized as recommended by the Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP), excluding Covid, Influenza and HPV vaccines, unless a physician's note explaining the exemption is submitted and reviewed by our medical team. If a delay in vaccination is required due to a history of multisystem organ failure or other life-threatening medical reasons, a letter from the physician documenting this is required.

Please submit your child’s official immunization records. Please ask your health care provider if you are unsure if your child has been fully immunized.

**Pre-Camp Self Evaluation Health Screening:**

* + If you or any family members are feeling unwell, please refrain from attending camp.
	+ If anyone in your family has tested positive for COVID within four days leading up to the camp start date, please do not attend.
	+ If a participant tests positive for COVID five days or more before camp, they must adhere to the guidelines provided by the CDC. The Epilepsy Foundation of Michigan will oversee monitoring and implementation of CDC guidelines for such cases.

**On-Site Screening:**

* + Upon arrival, all participants, staff, and volunteers will undergo screening for fever, lice, and infectious illnesses, which may include rapid COVID testing.
	+ Results will be assessed by our medical team, who will provide guidance on the next steps if screening is failed.

Physician Contraindication Form - [2025 Medical Contraindication Form](https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Adult-and-Childrens-Services/Children-and-Families/Immunization-Information/Immunization-Waivers/Medical/2025-Medical-Contraindication-Form.pdf)

**The following form is to be used as a guide if you are unsure of what vaccinations your child should have received to be fully vaccinated. This form is for your use only and is not required to be submitted to NSR. Please be sure to submit your campers’ official immunization records (MICR).**

**Chicken Pox / Varicella (Var)**

* Vaccinations (two dose series)

Vaccine #1: MM / DD / YYYY

Vaccine #2: MM / DD / YYYY

* Clinical Disease Date: MM / DD / YYYY
* Positive Titer Date: MM / DD / YYYY
* Physician documentation for
contraindication attached

**Measles, Mumps, Rubella (MMR)**

* Vaccinations (two dose series)

Vaccine #1: MM / DD / YYYY

Vaccine #2: MM / DD / YYYY

* Positive Titer Date: MM / DD / YYYY
* Physician documentation for
contraindication attached

**Hepatitis A (Hep A)**

* Vaccinations (two dose series)

Vaccine #1: MM / DD / YYYY

Vaccine #2: MM / DD / YYYY

* Positive Titer Date: MM / DD / YYYY
* Physician documentation for
contraindication attached

**Hepatitis B (Hep B)**

* Vaccinations (two - three dose series)

Vaccine #1: MM / DD / YYYY,

Vaccine #2: MM / DD / YYYY,

Vaccine #3: MM / DD / YYYY

* Positive Titer Date: MM / DD / YYYY
* Physician documentation for contraindication attached

**Inactivated Poliovirus (IPV)**

* Vaccinations (four – five dose series)

Vaccine #1: MM / DD / YYYY

Vaccine #2: MM / DD / YYYY

Vaccine #3: MM / DD / YYYY

Vaccine #4: MM / DD / YYYY

Vaccine #5: MM / DD / YYYY

* Positive Titer Date: MM / DD / YYYY
* Physician documentation for
contraindication attached

**Meningococcal (MenACWY)** (age 12)

* Vaccinations (two – three dose series)

Vaccine #1: MM / DD / YYYY

Vaccine #2: MM / DD / YYYY.

Vaccine #3: MM / DD / YYYY

* Positive Titer Date: MM / DD / YYYY
* Physician documentation for contraindication attached

**Hib / Haemophilus influenzae type b**

* Vaccinations (three-four dose series)

Vaccine #1: MM / DD / YYYY

Vaccine #2: MM / DD / YYYY

Vaccine #3: MM / DD / YYYY

Vaccine #4: MM / DD / YYYY

* Positive Titer Date: MM / DD / YYYY
* Physician documentation for contraindication attached

**TDaP / Diphtheria, tetanus, & acellular pertussis**

* Vaccinations (five dose series)

Vaccine #1: MM / DD / YYYY

Vaccine #2: MM / DD / YYYY

Vaccine #3: MM / DD / YYYY

Vaccine #4: MM / DD / YYYY

Vaccine #5: MM / DD / YYYY

* Positive Titer Date: MM / DD / YYYY
* Physician documentation for contraindication attached

**Pneumococcal**

* Vaccination (one to four dose series)

Vaccine #1: MM / DD / YYYY

Vaccine #2: MM / DD / YYYY

Vaccine #3: MM / DD / YYYY

Vaccine #4: MM / DD / YYYY

* Positive Titer Date: MM / DD / YYYY
* Physician documentation for contraindication attached

**Rotavirus (RV)**

* Vaccinations (two - three dose series)

Vaccine #1: MM / DD / YYYY

Vaccine #2: MM / DD / YYYY

* Positive Titer Date: MM / DD / YYYY
* Physician documentation for contraindication attached