Milton-Union Middle School

7630 Milton-Potsdam Rd. West Milton, Ohio 45383
Telephone: 937-884-7930 Fax: 937-884-7931

NOTICE: TO PARENTS / GUARDIANS OF 6TH GRADE STUDENTS:

There is a STATE MANDATED school vaccination requirement for students entering 7th grade. We are required by law to have written proof of their Tdap booster(Tetanus, Diphtheria, and Pertussis) shot AND Meningococcal vaccine, either from your doctor or a county health department BEFORE STARTING 7th grade. You can turn it in at the middle school office, or a Doctor or the Health department can mail, email or fax them to the school clinic. You can have the Doctor fill out & sign the bottom of this letter or provide a printed list. This requirement is STATE MANDATED so the school cannot make exceptions.

The Miami County Public Health Department in Troy has an immunization clinic. No one is denied due to the inability to pay. The Miami County Health Department is located in the Hobart Center at 510 West Water Street, Troy, Ohio. If you have any questions you may call their nursing department at (937) 573-3518. Go to the web address: http://www.miamicountyhealth.net for the latest clinic dates.

Please schedule appointments for these now or over the summer and do not wait until the fall when you are unable to get an appointment in time.

*****ALL STUDENTS MUST PROVIDE PROOF OF THESE VACCINATIONS PRIOR TO STARTING 7TH GRADE. ANY STUDENT WITHOUT THESE WILL BE EXCLUDED FROM SCHOOL STARTING THE 14TH DAY AFTER SCHOOL BEGINS AND ARE UNEXCUSED ABSENCES.*****

If you have any questions, please contact me: 884-7977. Fax number is: 937-884-7931. Email address is: ThompsonL@muschools.com. Address is Milton-Union Middle School, 7630 Milton-Potsdam Road, West Milton, Ohio 45383 (attention: clinic).

Thank you for your cooperation,
Ms. Lori Thompson, R.N., B.S.N, Milton-Union Nurse
Mrs. Katie Hartley, Milton-Union Middle School Principal

Name________________________ Date of Birth________________ Sex________

Address______________________________ Phone________________

Parent or Guardian____

Tdap Date:____________________

Meningococcal Date:________________

Physician's Signature__________________________ Phone:________________

Date__________ Address____________________________________