



Republic of the Philippines
Region: **CAR**



NOTIFICATION LETTER

DIVISION: _____
SCHOOL: _____
ADDRESS: _____
STUDENT'S NAME: _____ **GRADE:** _____
STUDENT'S ADDRESS: _____ **SECTION:** _____
NAME OF PARENT/ GUARDIAN: _____
CONTACT NUMBER: _____

Dear Parent/Guardian:

The Department of Health - Center for Health Development - Cordillera Administrative Region, in collaboration with the Department of Education Cordillera Administrative Region, is set to conduct a Selective Mass Measles for Kindergarten and Grades 1 to 6 learners through the *Project Baby Come Back to Bakuna*. This activity aims to address the continuing increase of measles cases in the region.

This Notification is being issued to inform you of the activity that will be conducted for the month of _____ 2019. To screen if your child/ward is eligible for vaccination, please check if your child/ ward has received the following:

- Anti-Measles vaccine or Measles-Mumps-Rubella Vaccine at 9 months old
- Measles-Rubella or Measles-Mumps-Rubella Vaccine at 12 months old
- Measles-Rubella or Measles-Mumps-Rubella Vaccine during the School-Based Immunization activity from 2015 to 2018
- Measles-Rubella or Measles-Mumps-Rubella Vaccine during the *Ligtas Tigdas* (Supplemental Immunization Activity) last October to November 2018

If you have checked two **(2) or more** boxes above, please **DISREGARD** filling up the Acknowledgment and Consent Portion below

If you have checked **one (1) or none** of the boxes above, please **ACCOMPLISH** the Acknowledgement and Consent Portion below

Should you have further questions/ clarifications on this matter, please get in touch with the School Health Personnel/ School Head or the DOH- CHD- CAR NIP Hotline: 0947195984.

Thank you.

Very truly yours,

(Name of School Health Personnel/ School Head)

ACKNOWLEDGMENT AND CONSENT

This is to acknowledge receipt of the Notification Letter regarding the conduct of *Project Baby Come Back to Bakuna*. I have also read and understood the information regarding the intended health service to be given to my child/ward.

(Please check in the box provided)

- Yes, I will allow my child/ward to be immunized with one (1) dose of Measles-Containing Vaccine
- No, I will not allow my child/ward to be immunized with one (1) dose of Measles-Containing Vaccine
Reason(Please specify): _____

Name and Signature of Parent/ Guardian