**CERTIFICATE OF IMMUNIZATION**

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Entering Class\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Check-up:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ( Month/Day/Year)

Parents Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

. (Street Address, City, State & Zip)

In accordance with New York State Public Health Law 2164 a Certificate of Immunization, signed by a Physician, listing exact dates, ***must be on file with the school on the first day of classes***.

**Minimum 3 full dose rates required for school attendance.**

|  |  |
| --- | --- |
|  | Month / Day / Year |
|  | Dose #1  | Dose #2 | Dose #3 | Booster | Booster |
| DPT/DT(Diphtheria, Pertussis, Tetanus) |  |  |  |  |  |
| TOPV(Trivalent Oral Polio Vaccine) |  |  |  |  |  |
| Hep B(Hepatitis B) |  |  |  |  |  |
| MMR(Measles, Mumps, Rubella) |  |  |  |  |  |
| PCV13(Pneumococcal Conjugate) |  |  |  |  |  |
| HIB(Haemophilus Influenza Type B) |  |  |  |  |  |
| Varicella / Chicken Pox Vaccine |  |  |  |  |  |

Tine Test (TB):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vision Screening Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lead Screening Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hearing Screening Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Tetanus Immunization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Check-Up\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_