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: _____