

IMMUNIZATION RECORD

Acceptable immunization records include a transcript, photocopy or transcription (by a school official or licensed healthcare provider) of the immunization portion of the student's cumulative health record from his or her previous school, licensed healthcare provider or the NYS Health Department.

Student Name: _____ Date of Birth: _____

IMMUNIZATIONS: (Give full dates): Please see attached NYS immunization requirements:

MMR: _____ MMR _____

Measles: _____ (History of disease: _____) (Presence of antibody: _____)

Rubella: _____ (Presence of antibody: _____)

Mumps: _____ (History of disease: _____) (Presence of antibody: _____)

Polio: (TOPV, OPV) _____

(IPV, eIPV) _____

DPT: _____

DTaP: _____

Dt: _____

Hib: _____

Hep B: _____

Varicella vaccine: _____ Varicella disease: Date _____

Other (Specify): _____

Lead test (required for Pre-K only) - date: _____ result: _____

Physician/Licensed Healthcare Provider's Signature: _____ Date: _____

Name (printed): _____

