

GREAT NECK PUBLIC SCHOOLS

Health Services

Immunization Record

NAME _____ DOB _____ SCHOOL _____

ADDRESS _____ PHONE _____ GRADE _____ TEACHER _____

Under section 2164 of the New York State Public Health Law, all children attending school, a day care center, or any preschool program must be immunized against Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella, Haemophilus Influenza b, Hepatitis B, & Varicella. Children who attend a preschool or day care program must also show evidence of lead screening. Please have your Health Care Provider fill in **month, day & year of immunizations**. **ALL DATES ARE REQUIRED.**

Your child **may not attend school without this information.**

◆ **DTP 3 Doses Required** (usually administered as either DTP, or DTaP)

1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___ 6. ___/___/___

◆ **Tdap 1 Dose Required** (all children entering 6th grade and who are 11 years of age (or older),

1. ___/___/___

◆ **OPV, IPV or EIPV: 3 Doses Required** (or as an alternative, 4 doses IPV administered after 1968, or 3 doses of EIPV)

1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___ 6. ___/___/___

◆ **MMR, MEASLES, MUMPS, RUBELLA: 2 Doses Measles Required** administered after 12 Months of age

MMR: 1. ___/___/___ 2. ___/___/___ or Serological Confirmation/Certification of Disease _____ DATE: ___/___/___
Or MEASLES: _____ MUMPS _____ RUBELLA _____
1. ___/___/___ 2. ___/___/___ 1. ___/___/___ 2. ___/___/___ 1. ___/___/___ 2. ___/___/___

◆ **HBV (HEPATITIS B) 3 Doses Required** (or Serologic confirmation)

1. ___/___/___ 2. ___/___/___ 3. ___/___/___

◆ **VARICELLA VACCINE (CHICKEN POX) 1 Dose Required (or proof of Disease from Health Care Provider)**

1. ___/___/___ 2. ___/___/___

For children entering Preschool program

◆ **Hib (HAEMOPHILUS INFLUENZA b) 3 Doses Required or 1 Dose administered after 15 months of age**

1. ___/___/___ 2. ___/___/___ 3. ___/___/___ OR (after 15 months of age) 1. ___/___/___

◆ **PREVNAR (PCV)** (All children born on or after Jan. 1, 2008)

1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ **LEAD SCREENING (Preschool)** _____

Optional Vaccines

◆ **HEPATITIS A Vaccine (HAV)** 1. ___/___/___ 2. ___/___/___

◆ **HUMAN PAPILOMAVIRUS (HPV)** 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___

◆ **MENINGOCOCCAL VACCINE** 1. ___/___/___ 2. ___/___/___

◆ **PPV (Pneumococcal Polysaccharide Vaccine)** 1. ___/___/___ 2. ___/___/___

◆ **OTHER VACCINES:** _____ 1. ___/___/___ 2. ___/___/___ 3. ___/___/___

➤ PPD/TB TEST: ___/___/___ Read ___/___/___ _____ mm Result: N___ P___

➤

*Children who have not been immunized may be admitted with 1 Dose of each: DPT, Polio, MMR, HBV & Varicella, **AND A WRITTEN NOTE FOR APPOINTMENTS** to return to the Health Care Provider for the remainder of the required immunizations.

** IF YOU DO NOT HAVE PROOF OF IMMUNIZATIONS, your child must be reimmunized.

PARENT SIGNATURE

PHYSICIAN'S SIGNATURE, ADDRESS, PHONE NUMBER

DATE ___/___/___

DATE: ___/___/___