



IMMUNIZATION RECORD

This form is a certificate of immunization for entry into school. It must be completed by your child's physician.

Child's Last Name: _____ Child's First Name: _____
 Home Address: _____
 Date of Birth: _____ Gender: _____ Telephone #: _____

Required Immunizations	Date of First Series			Date of Boosters	
	1st	2nd	3rd	1st	2nd
Td					
Diphtheria, Tetanus, Pertussis (DTaP)					
Polio (State Type: Oral or Injection)					
Pneumococcal Conjugate (PCV)					
Measles (Ten Day)			XX	XX	XX
Mumps			XX	XX	XX
Hepatitis B					
Varicella (Chicken Pox)					
	1st	2nd	3rd	4th	
Haemophilus Influenza Type (Hib)					
Optional Tests	Date	Result			
Sickle Cell Test					
Lead Test					
Tuberculin Test					

_____ Immunization is completed as required by New York State Law. Dates are included above.

_____ Immunization is in process and can be completed by _____ (date).

Signature of Examining Physician

Date

Print Name of Examining Physician

Address

I hereby agree to submit additional certification when immunization is complete. I understand that my child will be excluded from school if full certification has not been received by the school within ten days of the date specified by the examining physician.

Parent Signature

Date