winton road nursery school

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

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WRNS does not accept forms via fax.