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: 1.___/___/___ 2.___/___/___ MUMPS 1.___/___/___ 2.___/___/___ RUBELLA 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 PAPILLOMAVIRUS (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

_____

DATE___/___/___

PHYSICIAN'S SIGNATURE, ADDRESS, PHONE NUMBER

_____

_____

_____

DATE:___/___/___