



CERTIFICATE OF IMMUNIZATION

NAME : _____ DOB: _____ Sex: Female Male

SCHOOL: _____ GRADE: _____

NY STATE LAW REQUIRES THAT ALL STUDENTS ATTENDING SCHOOL MUST MEET THE FOLLOWING IMMUNIZATION REQUIREMENTS. (highlighted)

Vaccine		Date/Vaccine type	Vaccine		Date/Vaccine type
Hepatitis B (eg: HepB, HepB-Hib, DTaP-HepB-IPV)	1		Measles Mumps Rubella (first measles after 12 mo old)	1	
	2			2	
	3		Varicella (if > 12 years age)	1	
Diphtheria, Tetanus Pertussis (eg: DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		Hepatitis A	1	
	2			2	
	3		Influenza	1	
	4			2	
Tdap (required for entrance to 6 th 7 th , 8 th Grade)			Other		
Polio (eg: IPV, DTaP-HepB-IPV)	1		Pneumococcal		
	2				
	3				
Haemophilus Influenza type b (preK only)	1		Meningococcal		
	2				
	3				
	4				

Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox		History box	

Chickenpox History
<p>Check the box if this person has a Physician-certified reliable history of chickenpox. Reliable history may be based on:</p> <ul style="list-style-type: none"> <input type="radio"/> Physician interpretation of parent/guardian description of chickenpox <input type="radio"/> Physical diagnosis of chickenpox, or <input type="radio"/> Serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Physician/Practitioner name: _____ Date: ____ / ____ / ____ .

Signature _____ .

Address: _____ .

