Hawthorne Valley
WALDORF SCHOOL

2015-2016 Immunization Record

Student's Name: _____ Date of Birth: _____

See attached New York State immunization requirements

Immunization against a given disease means inoculation with approved licensed products administered in the amounts and manner on the date(s) listed below.

Vaccine	**#1**	**#2**	**#3**	#4	#5
DTaP, DTP					
Tdap					
Polio					
MMR					
Hepatitis B					
Hib					
Varicella					
PCV					

I certify that this child has received the immunizations as documented above.

_____ _____

Date Physician's Signature

Physician's Name: _____ Phone: _____

Physician's Address: _____

_____

***Note: If you have previously submitted your immunization record, you need only fill in the recent immunizations given since the record was submitted. Or, you can provide a current copy of the student's immunizations from doctor's office showing the updates.