

MAMARONECK UNION FREE SCHOOL DISTRICT VACCINATION ADMINISTRATION RECORD

Please return this report to your School Nurse as soon as your child's vaccinations have been given or updated. Obtaining proper vaccinations for your child is required by law and admission to school can be denied without them. District policy requires students provide proof of having had a minimum of one vaccine from each of the series of vaccines below in order to be permitted to enter school.

This form should be completed or updated annually. Please see the list of immunization requirements below:

NAME: _____ School year: September: _____ (year)

Date of birth: _____ Grade: _____ Teacher/Counselor: _____

School: CEN CHAT MAS MUR HMX HS Other: _____

Immunization Requirements:

As required by NY State Dept. of Education, a clinic or physician's verification of the following is needed for school attendance:

- **three (3) or more doses** of diphtheria toxoid containing vaccine (**DTaP, DT, or Td**); if born on/after 1/1/05 all three (3) doses must consist of tetanus toxoid & pertussis vaccine (**DTaP**)
- **one (1) dose** of tetanus toxoid, diphtheria, and acellular pertussis vaccine (**Tdap**) for students born on/after 1/1/94 entering 6th through 10th grades for the 2011-2012 school year
- **three (3) or more doses** of polio vaccine (**IPV**)
- **two (2) doses** of live measles vaccine♦: 1st dose on or after first birthday; 2nd dose for kindergarten
- **one (1) dose** of live mumps vaccine♦: administered on or after the 1st birthday
- **one (1) dose** of live rubella virus vaccine♦: administered on or after the 1st birthday
- **three (3) doses** of Hepatitis B vaccine (**HBV**)
- **one (1) dose** of varicella (chicken pox) vaccine born on/after 1/1/98 or born on/after 1/1/94 and entering grades 6 through 12

♦ MMR is preferred vaccine

In addition, for pre-kindergartners:

- Haemophilis influenzae type b vaccine (**Hib****): three (3) doses, or one (1) dose after 15 months of age
- Pneumococcal conjugate (**PCV**) vaccine born on/after 1/1/08: four (4) doses by 15 months of age given at age-appropriate times & intervals

VACCINATION ADMINISTRATION RECORD TO BE COMPLETED & SIGNED BY PHYSICIAN/PRACTITIONER:

VACCINE	DATE GIVEN:
DTaP 1* _____	DTaP 3* _____
DTaP 2* _____	DTaP 4 _____
DTP 5 _____	OR...
DT 1 _____	OR Td 1 _____
DT 2 _____	OR Td 2 _____
DT 3 _____	OR Td 3 _____
Tdap* _____	
IPV 1* _____	IPV 3* _____
IPV 2* _____	IPV 4 _____
VARICELLA VACCINE* _____	
VARICELLA VACCINE BOOSTER _____	
MMR 1* _____	
MMR 2* _____	
TST (LAST) MANTOUX _____	RESULT _____ ❖
BCG _____	

VACCINE	DATE GIVEN:
HEP B 1* _____	
HEP B 2* _____	
HEP B 3* _____	
OR (Adult formulation 2 dose series, ages 11 – 15 yrs)	
HEP B 1* (1.0 ML) _____	HEP B 2* _____
HIB 1** _____	
HIB 2** _____	
HIB 3** _____	
HIB 4** _____	
LEAD LEVEL** _____	RESULT _____
PNEUMOCOCCAL VACCINE	
1 _____	2 _____
3 _____	4 _____
MENINGOCOCCAL VACCINE _____	
HEP A 1 _____	HEP A 2 _____
HUMAN PAPILLOMAVIRUS VACCINE (HPV)	
1 _____	2 _____ 3 _____
OTHER _____	

❖ If Positive TST, Chest x-ray needed:
Date of CXR: _____ Results: _____
INH started: _____ X _____ months

- * Required for entry to school. DTaP is only given until the 7th birthday. DT is used for children < 7 y/o who should not get pertussis. Td is used for adolescents & adults but does not contain pertussis. Varicella & MMR must be on/after 1st birthday.

OFFICE STAMP NECESSARY HERE ↓

Physician/Practitioner's name (Print):
name (Print) _____

Address: _____

City/State/Zip: _____

SIGNED: _____

Telephone #: _____

Date of Completion: _____