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

  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

♦ MMR is preferred vaccine

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 _____

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

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 _____

* 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) _____ SIGNED: _____

Address: _____ Telephone #: _____

City/State/Zip: _____ **Date of Completion:** _____