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,… or any preschool program must be immunized against Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella, Hepatitis B, Varicella, Meningococcal, Haemophilus Influenza b & Prevnar. Children who attend a preschool…must also show evidence of lead screening.
Please have your Health Care Provider fill in **Month, Day & Year of ALL Immunizations. ALL DATES ARE REQUIRED**.

Your child <u>may not</u> attend school without this information.

*****PLEASE CHECK WITH YOUR DOCTOR FOR THE REQUIRED DOSES FOR YOUR CHILD ACCORDING TO ACIP GUIDELINES*****

- **DTaP** → **<u>3-5 Doses Required</u>** {Must have 1 Dose given AFTER age 4, prior to Kindergarten}
  1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____ 6. ____/____/____
- **Tdap**→ **<u>1 Dose Required</u>** {Mandatory Grades 6th -12th} **AND ALSO**{Depending on Age & Grade}
  1. ____/____/____
- **IPV** → **<u>3-5 Doses Required</u>** {Must have 1 Dose given AFTER age 4, prior to Kindergarten}
  1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____ 6. ____/____/____
- **HBV (HEPATITIS B)**→ **<u>3 Doses Required</u>**
  1. ____/____/____ 2. ____/____/____ 3. ____/____/____ Additional Doses: ____/____/____ ____/____/____ ____/____/____
- **MMR**→ **<u>2 Doses Required</u>** {1st Dose Must be given on or After First Birthday. 2nd Dose Required for Kindergarten.}

  MMR: 1. ____/____/____ 2. ____/____/____

  Or MEASLES: 1.____/____/____ 2. ____/____/____ MUMPS 1. ____/____/____ 2.____/____/____ RUBELLA 1. ____/____/____ 2.____/____/____
- **VARICELLA VACCINE (CHICKEN POX)**→ **<u>2 Doses Required</u>** {1st Dose Must be given on or After First Birthday. 2nd Dose Required for Kind., 1st, 2nd & 3rd Grade AND 6th, 7th, 8th, & 9th Grade}
  1. ____/____/____ 2. ____/____/____ <u>Or proof of Disease from Health Care Provider</u>→ DATE: 1. ____/____/____
- **MenACWY / Menactra / MCV4 / Menveo VACCINE**→ **<u>1-2 Doses Required</u>** {1st Dose Required for 7th Grade. 2nd Dose Required on or After Age 16, &/Or Entering 12th Grade.}
  1. ____/____/____ 2. ____/____/____

<u>For children entering Preschool program</u>

- **Hib (HAEMOPHILUS INFLUENZA b)**→ **<u>1-4 Doses Required</u>** {Depending on Age & Grade}
  1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____
- **PREVNAR (PCV)** → **<u>1-4 Doses Required</u>** {Depending on Age & Grade}
  1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____
- **LEAD SCREENING** →**<u>Required for Preschool</u>** → **____/____/____** → **_____**

<u>Optional Vaccines</u>

- **HEPATITIS A Vaccine (HAV)**→ 1. ____/____/____ 2. ____/____/____
- **HUMAN PAPILLOMAVIRUS (HPV)**→ 1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____
- **PPV (Pneumococcal Polysaccharide Vaccine)** → 1. ____/____/____ 2. ____/____/____
- **ROTATEQ**→ 1. ____/____/____ 2. ____/____/____ 3. ____/____/____
- **OTHER VACCINES: _____**→ 1. ____/____/____ 2. ____/____/____ 3. ____/____/____

➢ PPD/TB TEST→ ____/____/____ Read ____/____/____ → _____ mm → Result: N___ P___

Children who have not been immunized may be admitted <u>with 1 Dose of **each required vaccine series</u> & has **WRITTEN** age appropriate appointments to complete the series according to the ACIP guidelines.**

<u>PHYSICIAN'S SIGNATURE</u>, **<u>STAMP</u>**, ADDRESS, PHONE NUMBER

_____

DATE: ____/____/____ _____

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