

# NORTH SHORE SCHOOL DISTRICT HEALTH SERVICES DEPARTMENT

## IMMUNIZATION INFORMATION

New York State Public Health Law, Section 2164 mandates that schools shall not permit a child to be admitted unless the parent provides the school with a certificate of immunization.

The required immunizations are:

- 3-5 doses of Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (usually administered as DTP, DTaP or TD), depending on grade. Check with your healthcare provider.
- A 5<sup>th</sup> dose of DTaP is required if the 4<sup>th</sup> dose was received prior to age 4.
- 1 dose Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap) entering 6<sup>th</sup> grade.
- 3 to 4 doses of polio vaccine. 4 doses or 3 doses if the 3<sup>rd</sup> dose was received at 4 years of age or older.
- 3 doses of Hepatitis B.
- 2 doses of MMR.
- 2 doses of Varicella are required to enter grades K - 1 and 6 - 7.  
If your child had the Varicella disease (Chickenpox), proof must be documented by healthcare provider.
- 1 or 2 doses of Meningococcal conjugate vaccine, entering 7<sup>th</sup> grade, 1 dose, entering 12<sup>th</sup> grade; 2 doses or 1 dose if the dose was received at 16 years of age or older.

All of the above immunizations must be documented by your health care provider. All immunizations must specify the exact date each immunization was administered.

**Your child will not be permitted to attend school without the necessary verification of immunizations.**

5/8/17

**NORTH SHORE SCHOOL DISTRICT**

# HEALTH SERVICES DEPARTMENT

Name \_\_\_\_\_ DOB \_\_\_\_\_

**The following immunizations are required. *Month, Day and Year must be specified.***  
**Please provide exact dates.**

DPT/DTaP Series #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_ #5 \_\_\_\_\_

OPV/IPV Series #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

Hepatitis B Series #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

MMR Vaccine #1 \_\_\_\_\_ #2 \_\_\_\_\_

Varicella #1 \_\_\_\_\_ #2 \_\_\_\_\_ \*Had Chickenpox? Date \_\_\_\_\_

\*Proof of Varicella (Chickenpox) must be documented by healthcare provider.

Tdap Vaccine entering 6<sup>th</sup> grade \_\_\_\_\_

Meningococcal entering 7<sup>th</sup> grade \_\_\_\_\_

Meningococcal entering 12<sup>th</sup> grade #1 \_\_\_\_\_ #2 \_\_\_\_\_ 2 doses or 1 dose if the dose was received at 16 years of age or older

## Recommended

HIB Series #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

PCV Series #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician's Signature \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

**This form must be returned to the Health Office before your child may attend school.**  
**Physician's Signature Required.**