



Westchester Day School 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. 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: _____

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, Td; 1 of the 3 doses can be Tdap**)
- **one (1) dose of tetanus toxoid, diphtheria, and acellular pertussis vaccine (Tdap)** for students born after 1/1/94 entering 6th through 9th grades for the 2010-2011 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 (girls greater than 11 years old are exempt)
- **three (3) doses** of Hepatitis B vaccine (**HBV**)
- **one (1) dose** of varicella (chicken pox) vaccine

♦ 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**
- **one (1) dose** of varicella vaccine: for all children born on or after Jan. 1, 2000

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

VACCINE DATE GIVEN:

DTaP 1 * _____ DtaP 2 * _____

DTaP3 * _____ 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 * (1.0 ML) _____

HIB 1 ** _____

HIB 2 ** _____

HIB 3 ** _____

HIB 4 ** _____

LEAD LEVEL ** _____ RESULT _____

PNEUMOCOCCAL VACCINE

1 _____ 2 _____ 3 _____

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. Tdap is recommended for all 11 & 12 y/o. Varicella & MMR must be after 1st birthday.
** Required for entry to Pre K (3 before 15 months of age, or 1 dose after)



OFFICE STAMP NECESSARY HERE ↓

Physician/Practitioner's name (Print) _____

Address: _____

City/State/Zip: _____

SIGNED: _____

Telephone #: _____

Date of Completion: _____