

## WESTCHESTER DAY SCHOOL VACCINATION ADMINISTRATION RECORD

PLEASE return this report to the 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
- **three (3) or more doses** of polio vaccine (**IPV**)
- **two (2) doses** of live measles vaccine ♦: 1<sup>st</sup> dose on or after first birthday; 2<sup>nd</sup> dose for kindergarten
- **one (1) dose** of live mumps vaccine ♦: administered on or after the 1<sup>st</sup> birthday
- **one (1) dose** of live rubella virus vaccine ♦: administered on or after the 1<sup>st</sup> 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* _____	
<b>OR</b> (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 7<sup>th</sup> 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 1<sup>st</sup> 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:** \_\_\_\_\_