

**NEW YORK STATE LAW REQUIRES A CERTIFICATE OF IMMUNIZATION
BEFORE ADMITTANCE TO SCHOOL**

	<u>DPT /DTaP</u>	<u>OPV/IPV</u>	<u>MMR</u>	<u>MUMPS</u>	<u>HIB/HBVC</u>	<u>HEPATITIS B</u>
	/ /	/ /	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /	/ /	/ /
	/ /	/ /	<u>MEASLES</u>	<u>RUBELLA</u>	/ /	/ /
	/ /	/ /	/ /	/ /	/ /	/ /
DT	/ /	/ /	/ /	/ /	/ /	/ /
Td	/ /	<u>HEPATITIS A</u>	<u>HPV</u>	<u>Pneumococcal</u>	<u>VARICELLA (Vaccine)</u>	/ /
Tdap	/ /	/ /	/ /	/ /	<u>VARICELLA (Vaccine)</u>	/ /
	/ /	/ /	/ /	<u>Meningococcal</u>	<u>VARICELLA (Disease)</u>	/ /
	/ /	/ /	/ /	/ /	/ /	/ /

<u>MANTOUX TEST</u>	<u>CHEST X-RAY</u>	<u>LEAD SCREENING</u>	<u>INFLUENZA VACCINE</u>	<u>OTHER VACCINE</u> (Indicate)	<u>OTHER TEST</u> (Indicate)
/ /	/ /	/ /	/ /	/ /	/ /
<u>RESULT</u>	<u>RESULT</u>	<u>RESULT</u>		<u>RESULT</u>	<u>RESULT</u>

I certify that the aforementioned student has completed all required immunizations.

Doctor's Signature _____ Date: _____

I certify that the aforementioned student will have completed all immunizations by: _____

Doctor's Signature _____ Date: _____

Significant Medical/Surgical History _____

Additional findings on physical exam: **Date** _____ **Findings:** _____

Additional Medications: _____ (Medication orders are valid for the current school year)
 Name: _____ Dosage/Time: _____
 Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____
 I assess this student to be self-directed Yes No Student may self carry and self administer medication Yes No
 Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional 3 day supply of medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

Additional Recommendations/ Referrals: _____

 Provider's Signature: _____ Phone: _____ (Provider's stamp below)
 Provider's Name/Address: _____ Fax: _____
 Parent Signature: _____ Date: _____