MAMARONECK UNION FREE SCHOOL DISTRICT
VACCINATION ADMINISTRATION RECORD

Please return this report to your **School Nurse** as soon as your child's vaccinations have been given and/or updated. Obtaining proper vaccinations for your child is required by law and admission to school can be **denied** without them. Vaccines must follow the Advisory Committee for Immunization (ACIP) guidelines.

This form should be completed and/or updated annually. Please see the list of immunization requirements below:

NAME: ______________________ **DATE:** ______________

DOB: ______________ **GRADE:** _______ **TEACHER/COUNSELOR** ______________

School: ○ CEN ○ CHAT ○ MAS ○ MUR ○ HMX ○ HS ○ Other: ______________

Immunization Requirements:

As required by NY State Dept. of Education, Health Care Provider verification of the following is needed for school attendance:

- **DTaP : three - five (3-5) doses** of diphtheria and tetanus toxoid-containing vaccine and acellular pertussis vaccine
- **Tdap : one (1)dose** - students 11 years of age or older entering grade 6 through 12 are required to have one dose of Tdap
- **IPV : three – four (3-4) doses** of polio vaccine
- **MMR : two (2) doses** of live measles, mumps and rubella vaccine (K-12)
- **HBV : three (3) doses** of Hepatitis B vaccine at intervals recommended by the ACIP
- **VARICELLA: – two (2) doses** of Varicella (chicken Pox) entering kindergarten, Grade 1, Grade 6 and Grade 7
- **MENINGOCOCCAL: one (1) dose** entering Grade 7, **one-two (1-2) doses** at age 16, entering Grade 12

In addition, for pre-kindergartners:

- **Hib** Haemophilis influenzae type b vaccine: 1-4 doses
- **PCV** Pneumococcal conjugate **(PCV)** 1-4 doses (age appropriate)

VACCINATION ADMINISTRATION RECORD
TO BE COMPLETED & SIGNED BY THE HEALTH CARE PROVIDER

VACCINE — DATE GIVEN:

DTaP 1 ______________ DTaP 3 ______________

DTaP 2 ______________ DTaP 4 ______________

DTAP 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 1 ______________

VARICELLA 2 ______________

MMR 1 ______________

MMR 2 ______________

TST (LAST) MANTOUX ______________ RESULT ______________ ❖

BCG ______________

❖ If Positive TST, Chest x-ray needed:
Date of CXR: ______________ Results: ________
INH started: ______________ X ________ months

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 ______________

PNEUMOCOCCAL VACCINE

1 ________ 2 ________ 3 ________ 4 ________

MENINGOCOCCAL VACCINE ______________

MENINGOCOCCAL VACCINE ______________

HEP A 1 ______________ HEP A 2 ______________

HUMAN PAPILLOMAVIRUS VACCINE (HPV)

1 ________ 2 ________ 3 ________

OTHER ______________

OFFICE STAMP NECESSARY HERE

Healthcare Provider
NAME (Print) ______________ SIGNATURE: ______________

ADDRESS: ______________ TELEPHONE #: ______________

CITY/STATE/ZIP: ______________ DATE: ______________

3/16