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. Failure to provide acceptable evidence of immunizations within fourteen days of entry may lead to exclusion from school. This period may be extended up to thirty days for those transferring from out of state or abroad. 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 (pre k – 12)
- **VARICELLA: – two (2) doses** of Varicella (chicken Pox) (K- 12)
- **MENINGOCOCCAL: one (1) dose** entering Grade 7,8,9,10 &11, one-**two (1-2) doses** at age 16, entering Grade 12

In addition, for pre-kindergartners:

- **Hib** Haemophilus influenzae type b vaccine**:** 1-4 doses
- **PCV** Pneumococcal conjugate (**PCV**) 1-4 doses (age appropriate)
- **MMR & Varicella :** one (1)dose

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: ________

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**:** ____________________

5/14/20