



Great Neck Public Schools
Phipps Administration Building
Office of Registration

345 Lakeville Road, Great Neck, NY 11020 (516) 441-4080

residency@greatneck.k12.ny.us

Welcome to the Great Neck School District 2024-25

Great Neck Public Schools can only register your children once your children are living full time and sleeping in a house or apartment inside our district boundaries.

Registration is a three-step process.

Step one-move in, if you are NOT living in Great Neck, you are not permitted to register for school.

Step two- complete and submit the **Online Registration Application**: <https://www.greatneck.k12.ny.us/Page/14151>. After the application is submitted our staff will review the application within 1-3 school business days. All applications are reviewed in the order they are received. **Applications missing documents will delay your registration.**

Step three-Once your application is fully approved and all documents are received, you will receive an email to call our office to make an in-person appointment to verify your original documents. When that appointment is completed, your student's enrollment will take place.

WE DO NOT ACCEPT UNSCHEDULED WALK-IN REGISTRATION APPLICATIONS

Before you begin the online registration, please gather the following documents and scan them to your computer so you can upload them during the registration process.

The following documents are required for registration and can be uploaded into the Online Registration System. In the event the family is not able to present the required documentation, an in-person appointment may be requested by our registration team to determine what other documents will be acceptable to register the student in school.

Acceptable Proof of Residence: All of these will be uploaded while filling out the Online Application.

Homeowners, please provide one of the following: Deed, Current Town or North Hempstead Tax Bill (If you need a copy call (516) 869-7800), Closing statement, Proprietary lease (for Co-op).

Renters, please provide the following: Lease (all pages with complete landlord contact information), Rental Agreement (all pages with complete landlord contact information)

**** Both Lease and Rental Agreement must be accompanied with the local village/town official rental permit for that property (must be supplied to the tenant by the landlord).**

3 Pieces of Current Official Mail (i.e. bank statements, credit card statements, insurance bills, cell phone bills, and utility bills, etc., dated current or past month only).

Additional Documentation:

Student Records The following student records are also required:

- **Proof of Age (Original Birth Certificate).** If not in English an Official Notarized Translation is required. **(All students)**
- **Up-to-Date Immunization Record** signed and stamped by a doctor. **Public School only**
- **Physical** (by a New York State Doctor within 30 days of starting school, the physical must have been performed within the last 12 months. **Public School only**
- **School Records** (i.e. report card, official transcript, course schedule. **Public School only**
- If a student is receiving special education services, a copy of the **IEP is required.**

Proof of Guardianship/Parental Relationship. (Not required if parent is listed on birth certificate)
If parents are divorced, documents indicating residential custody of the student are required.

Please do not hesitate to call if you have any questions. You can also find information regarding registration, on the district website at [greatneck.k12.ny.us](https://www.greatneck.k12.ny.us).

Online Registration Applications

Complete requirements, forms and directions can be found at: <https://www.greatneck.k12.ny.us/Page/14151>

From the **Great Neck Public School Home Page – Select Administration
Registration and Attendance > Great Neck Registration and Online Application**

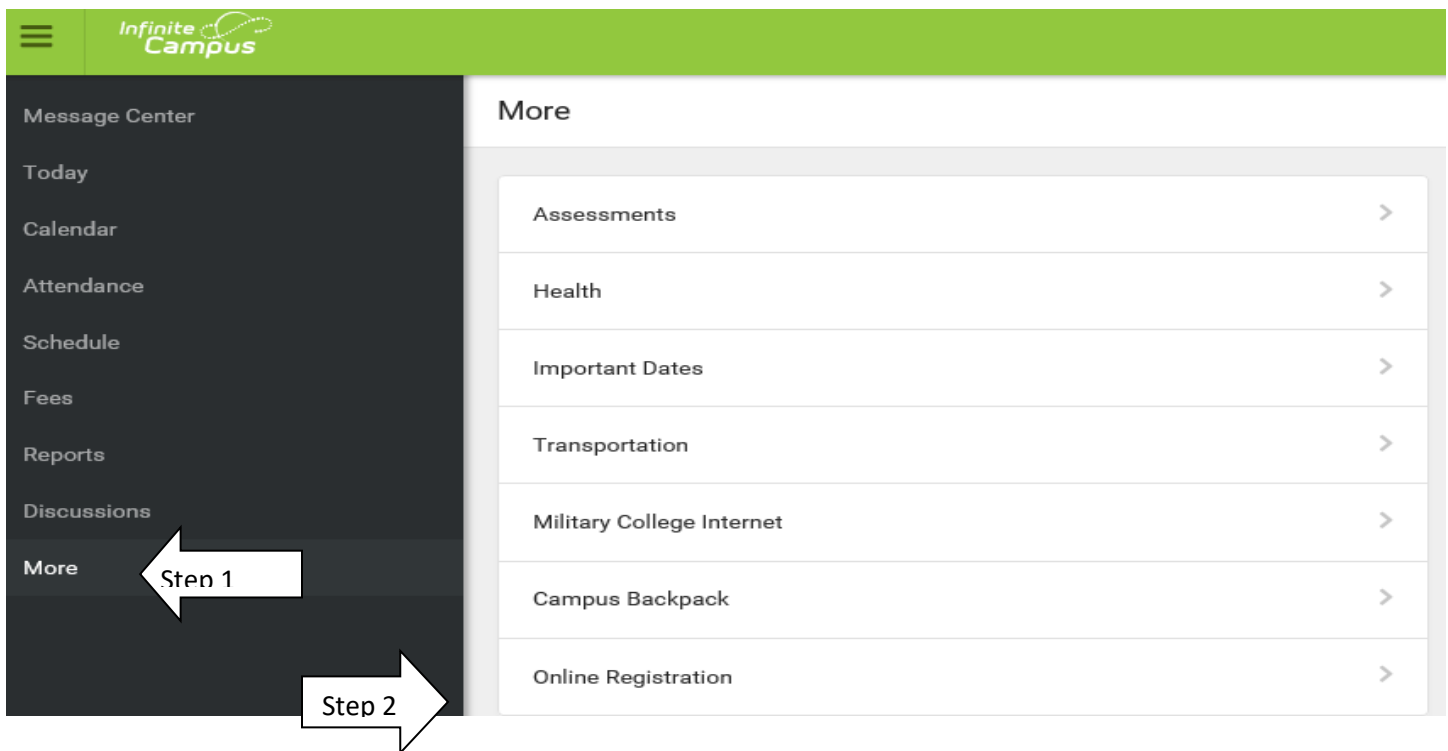
Prior to starting the Application please download the **required forms** for Public School Forms UPK and review the attached Checklist to see what additional information needs to be collected and uploaded.

Select the link **Online Registration Application** and you will be able to begin the Application.

If you DO NOT HAVE a Campus Parent Portal Account see the back of this page for directions.

- Login into the Campus Parent Portal > Step 1: Select More > Step 2: Select Online

If you DO HAVE a Campus Parent Portal Account then simply login and follow the screens below.



- **Very Important Registration Year – Select the 24-25 School Year from the dropdown**
- **The application will pull any current information which was stored in Infinite Campus. Please update any changes or add any additional required information.**
- Please navigate the program by selecting Next or Save and Continue.
- On the tab **Non School Age Brothers and Sisters**, please let us know about any **younger siblings**. Please do not add any students who are currently enrolled in school, whether it is public or private.


If you do not have Campus Parent Portal Account follow the directions on the Great Neck Registration and Online Application Web Page. Select the link Online Registration Application and you will be able to begin registration.

Click on Start New Registration: **Very Important the Registration Year needs to be the 24-25 School Year from the dropdown.**

Infinite Campus Online Registration

Please complete the information below to begin the registration process.

Parent/Guardian First Name	First Name *
Parent/Guardian Last Name	Last Name *
Date of Birth (MM/DD/YYYY)	*
Registration Year	24-25
Email Address	myemail@gmail.com
Previously Attended this District	<input type="checkbox"/>
Please type the letters you see displayed in the image below	

☒ I'm not a robot  reCAPTCHA Privacy - Terms

Begin Registration

You will receive a confirmation number. Enter your name and **Submit**

Infinite Campus Online Registration Application Number 1573

Welcome First Name Last Name! Please type in your first and last name in the box below.

By typing your name into the box below you attest that you are the person authenticated into this application or an authorized user of this account, and the data you are entering/verifying is accurate and true to the best of your knowledge.

First Name Last Name *

Submit

Infinite Campus Online Registration Application Number 1573

* Indicates a required field

▼ Student(s) Primary Household ▼ Parent/Legal Guardian ▼ Public School Families Only Emergency Contacts ▼ Non School Age Brothers and Sisters

Student Completed

▼ Home phone:

Home Phone () - *

Next >

Home Address **** Upload Residency/Proof of Mail

Save/Continue

Navigate the application by selecting Next and Save and Continue.
PLEASE SUMBIT the APPLICATION and Confirm you received an email from Parent Support.



Great Neck Public Schools, Office of Registration and Attendance

345 Lakeville Road, Great Neck, NY 11020

residency@greatneck.k12.ny.us (516) 441-4080

Name: _____ Date: _____ Application #: _____

Public School Registration Checklist 2024-25

*****Please include the application number in all correspondence*****

- ____ Deed, Closing Statement, or Current School/Village Tax Bill
Or
- ____ Proprietary Lease (Co-op)
Or
- ____ Lease (all pages with complete landlord contact information)
Rental Agreement (all pages with complete landlord contact information)
** Both Lease and Rental agreement must be accompanied with the local village/town official rental permit for that property (should be supplied to the tenant by the landlord). Permit will be verified.
- ____ Current Mail 3 Different Pieces of Official Mail, utility bills work best-shipping labels are unacceptable, must be stamped within the past 30 days.
- ____ Certification of Residency (notarized)
- ____ Parent/Guardian Photo ID: You are Required to add all Parents listed on the Birth Certificate, to the Online Application in the Parent Section.
- ____ Custody Agreement or Notarized Affidavits if applicable. A secondary mailing will be set up for all non-household parents
- ____ Original Birth Certificate (Original and an official, notarized translation to English, if necessary)
- ____ Immunization Record (stamped by a physician) *** REQUIRED to Complete Registration.
- ____ Physical, performed and stamped within the last 12 months by a New York State Doctor.
*** REQUIRED to Complete Registration.
- ____ Home Language Questionnaire (one form for EACH student)
- ____ Dental Form – Elementary Only (one form for EACH student)
- ____ Report Card/Transcript. Important for placement: Prior School Information needs to be entered before submitting the application. For Kindergarten enrollment please list the current Pre-School or Daycare Program, if applicable.
- ____ Please make sure you SUBMIT the application. An email from “Parentsupport” will be sent as soon as you Submit the application letting you know it has been submitted. Check your email and make sure you receive this verification. All applications are reviewed in the order they are received. Please allow 1-3 business days for our staff to review your application.

If the application is complete and all documents are uploaded and are correct, you will receive an email to call our office to make an in-person appointment to verify your original documents. Once that appointment is complete your student's enrollment will take place. WE DO NOT ACCEPT UNSCHEDULED WALK-IN REGISTRATION APPLICATIONS.

If any of the documents are missing or information is incomplete, your application will be placed on HOLD, and you will receive an email letting you know what is missing.
Incomplete applications and/or missing documents will delay the processing.



GREAT NECK PUBLIC SCHOOLS
REGISTRATION OFFICE
345 LAKEVILLE ROAD GREAT NECK, NY 11020

CERTIFICATION OF RESIDENCY (required document)

(Affidavit is valid for one year from date of notary signature, one affidavit per application)

This is to certify that I (we), _____
(parent (s) names listed above)

understand this statement is being made UNDER THE PENALTIES OF PERJURY, so that all my school aged child/children listed below

_____, _____
, _____

(print child/all children's name above living at this address)

may be admitted to the schools of the Great Neck Public Schools.

I am currently residing (living) at _____
(Address) _____

I attest that it is my legal residence. I further certify that I **do not** maintain another residence outside the boundaries of the Great Neck School District. **I further certify I will be living with my children while they are attending Great Neck School.**

I understand that if I or the above mention child(ren) is (are) found not to be a legitimate residents of the Great Neck Union Free School District, **that I WILL BE LEGALLY RESPONSIBLE FOR AND WILL PAY THE SCHOOL DISTRICT'S ANNUAL TUITION RATE PER CHILD (Minimum range is \$20,587.00 - \$28,517.00), RETROACTIVE TO THE FIRST DAY OF ADMISSION, ALONG WITH ANY COSTS ASSOCIATED WITH ENROLLING YOUR CHILD" and MY CHILD/CHILDREN WILL BE DISENROLLED.** I also realize that theft of governmental services is a crime punishable under the State Penal Law and that a false statement made in connection with this application will make me liable to criminal prosecution. I understand that the school district will make an announced home visit for purposes of residency verification. In addition, the district may make an unannounced home visit for the purpose of residency verification.

I further understand that if I move out of the home listed above, I will immediately notify the school district.
By signing below, I admit to having read and understood the above conditions.

Signature of Parent/Person in Parental Relation

Date

Sworn to before me

This _____ day of _____, 20____

NOTARY PUBLIC

I have read and understood the above and am certifying the resident understands the statement they are signing. Please attach copy of ID.

Signature of Translator

Relationship

Phone

Sworn to before me

This _____ day of _____, 20____

NOTARY PUBLIC

2024-2025 School Year

New York State Immunization Requirements

for School Entrance/Attendance¹

NOTES:
All children must be age-appropriately immunized to attend school in NYS. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the “[ACIP-Recommended Child and Adolescent Immunization Schedule](#).” Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements **MUST** be read with the footnotes of this schedule

Vaccines	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) ²	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older or 3 doses if 7 years or older and the series was started at 1 year or older	3 doses	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap) ³	Not applicable		1 dose	
Polio vaccine (IPV/OPV) ⁴	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR) ⁵	1 dose	2 doses		
Hepatitis B vaccine ⁶	3 doses	3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine ⁷	1 dose	2 doses		
Meningococcal conjugate vaccine (MenACWY) ⁸	Not applicable		Grades 7, 8, 9, 10 and 11: 1 dose	2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) ⁹	1 to 4 doses	Not applicable		
Pneumococcal Conjugate vaccine (PCV) ¹⁰	1 to 4 doses	Not applicable		

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019, and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)

a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.

c. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 9: 10 years; minimum age for grades 10, 11, and 12: 7 years)

a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.

b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2023-2024, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 9; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 10, 11, and 12.

c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)

a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.

c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016, should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016, must not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)

a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine

a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute “dose 4” for “dose 3” in these calculations).

b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)

a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 through 10: 10 years; minimum age for grades 11 and 12: 6 weeks).

a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.

b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.

c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)

a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.

c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.

d. If dose 1 was received at 15 months or older, only 1 dose is required.

e. Hib vaccine is not required for children 5 years or older.

f. [For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.](#)

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)

a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.

c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.

d. If one dose of vaccine was received at 24 months or older, no further doses are required.

e. PCV is not required for children 5 years or older.

f. [For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.](#)

For further information, contact:

**New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437**

**New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433**

2370

New York State Department of Health/Bureau of Immunization
health.ny.gov/immunization

05/23

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.

BMI _____ kg/m2

Percentile (Weight Status Category): ☐ < 5th ☐ 5th- 49th ☐ 50th- 84th ☐ 85th- 94th ☐ 95th- 98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ Not Done

Hypertension: ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
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☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail					<input type="checkbox"/>
Notes					
Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					Not Done
Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> Other Restrictions:					
Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.					
Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.					
<small>*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.</small>					
MEDICATIONS					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					

GREAT NECK PUBLIC SCHOOLS

Health Services

Immunization Record

NAME _____ DOB _____ SCHOOL _____

ADDRESS _____ PHONE _____ GRADE _____ TEACHER _____

Under section 2164 of the New York State Public Health Law, all children attending school, ... or any preschool program must be immunized against Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella, Hepatitis B, Varicella, Meningococcal, Haemophilus Influenza b & Prevnar. Children who attend a preschool... must also show evidence of lead screening.

Please have your Health Care Provider fill in Month, Day & Year of ALL Immunizations. ALL DATES ARE REQUIRED.

Your child may not attend school without this information.

****PLEASE CHECK WITH YOUR DOCTOR FOR THE REQUIRED DOSES FOR YOUR CHILD ACCORDING TO ACIP GUIDELINES****

- ♦ **DTaP → 3-5 Doses Required** {Must have 1 Dose given AFTER age 4, prior to Kindergarten}

1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____ 6. ____/____/____

- ♦ **Tdap → 1 Dose Required** {Mandatory Grades 6th -12th}

1. ____/____/____

- ♦ **IPV → 3-5 Doses Required** {Must have 1 Dose given AFTER age 4, prior to Kindergarten}

1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____ 6. ____/____/____

- ♦ **HBV (HEPATITIS B) → 3 Doses Required**

1. ____/____/____ 2. ____/____/____ 3. ____/____/____ Additional Doses: ____/____/____ ____/____/____ ____/____/____

- ♦ **MMR → 2 Doses Required** {1st Dose Must be given on or After First Birthday. 2nd Dose Required for Kindergarten.}

MMR: 1. ____/____/____ 2. ____/____/____

Or
MEASLES: 1. ____/____/____ 2. ____/____/____ MUMPS 1. ____/____/____ 2. ____/____/____ RUBELLA 1. ____/____/____ 2. ____/____/____

- ♦ **VARICELLA VACCINE (CHICKEN POX) → 2 Doses Required** {1st Dose Must be given on or After First Birthday.

2nd Dose Required for Kind., 1st, 2nd, 3rd, 4th, 6th, 7th, 8th, 9th, 10th & 11th Grade}

1. ____/____/____ 2. ____/____/____ Or proof of Disease from Health Care Provider → DATE: 1. ____/____/____

- ♦ **MenACWY / Menactra / MCV4 / Menveo VACCINE → 1-2 Doses Required** {1st Dose Required for 7th, 8th, 9th, 10th & 11th Grade.

2nd Dose Required on or After Age 16, &/or Entering 12th Grade.}

1. ____/____/____ 2. ____/____/____

For children entering Preschool program

- ♦ **Hib (HAEMOPHILUS INFLUENZA b) → 1-4 Doses Required** {Depending on Age & Grade}

1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____

- ♦ **PREVNAR (PCV) → 1-4 Doses Required** {Depending on Age & Grade}

1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____

- ♦ **LEAD SCREENING → Required for Preschool → ____/____/____ → _____**

Optional Vaccines

- ♦ **HEPATITIS A Vaccine (HAV) → 1. ____/____/____ 2. ____/____/____**

- ♦ **HUMAN PAPILLOMAVIRUS (HPV) → 1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____**

- ♦ **PPV (Pneumococcal Polysaccharide Vaccine) → 1. ____/____/____ 2. ____/____/____**

- ♦ **ROTATEQ → 1. ____/____/____ 2. ____/____/____ 3. ____/____/____**

- ♦ **OTHER VACCINES: _____ → 1. ____/____/____ 2. ____/____/____ 3. ____/____/____**

➤ **PPD/TB TEST → ____/____/____ Read ____/____/____ → _____ mm → Result: N__ P__**

****Children who have not been immunized may be admitted with 1 Dose of each required vaccine series & has WRITTEN age appropriate appointments to complete the series according to the ACIP guidelines.****

PHYSICIAN'S SIGNATURE, STAMP, ADDRESS, PHONE NUMBER

DATE: ____/____/____



STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Elisa Alvarez, Associate Commissioner Office of
Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLO)

Dear Parent or Person in Parental Relation:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
		<input type="checkbox"/> Male
Month	Day	Year
<input type="checkbox"/> Female		
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to

HOME LANGUAGE CODE

Language Background

(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1	<input type="checkbox"/> Parent 2	_____
	<input type="checkbox"/> Guardian(s)		_____
			<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not speak
			<i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not read
			<i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not write
			<i>specify</i>

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT
INFORMATION SYSTEM:

District Name (Number) & School:

Address:

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes* No Not sure

☐ ☐ ☐ *If yes, please explain: _____

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

10a. Has your child ever been referred for a special education evaluation in the past? ☐ No ☐ Yes* *Please complete 10b below

10b. *If referred for an evaluation, has your child ever received any special education services in the past?

☐ No ☐ Yes – Type of services received: _____

Age at which services received (Please check all that apply):

☐ Birth to 3 years (Early Intervention) ☐ 3 to 5 years (Special Education) ☐ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ☐ No ☐ Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

12. In what language(s) would you like to receive information from the school? _____

Signature of Parent or of Person in Parental Relation

Month: Day: Year:

Date

Relationship to student: ☐ Parent ☐ Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ No ☐ Yes

**DATE OF INDIVIDUAL
INTERVIEW:

Mo. Day Yr.

OUTCOME OF
INDIVIDUAL
INTERVIEW:

- ☐ ADMINISTER NYSITELL
☐ ENGLISH PROFICIENT
☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL
ADMINISTRATION:

Mo. Day Yr.

PROFICIENCY LEVEL
ACHIEVED ON
NYSITELL:

- ☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Año escolar 2024-2025

Requisitos de vacunación del estado de Nueva York para inscribirse/asistir a la escuela¹

NOTAS:
Los niños que están en prekindergarten deben tener las vacunas correspondientes a su edad. La cantidad de dosis depende del programa recomendado por el Comité Asesor sobre Prácticas de Vacunación (Advisory Committee on Immunization Practices, ACIP). Los intervalos entre las dosis de vacunas deben corresponder al programa de vacunación recomendado por el ACIP para personas de 0 a 18 años. Las dosis aplicadas antes de la edad mínima o de los intervalos mínimos no son válidas y no se tienen en cuenta al calcular la cantidad de dosis que se mencionan abajo. Consulte las notas al pie de página para obtener información específica sobre **cada** vacuna. Los niños que se inscriben en clases sin grado deben cumplir los requisitos de vacunación de los grados para los que son equivalentes en edad.

Se **DEBEN** leer los requisitos de dosis con las notas al pie de página de este programa

Vacunas	Prekindergarten (guardería infantil, programa Head Start, guardería o pre-K)	Kindergarten y 1.º, 2.º, 3.º, 4.º y 5.º grado	6.º, 7.º, 8.º, 9.º, 10.º y 11.º grado	12.º grado
Vacuna con toxoide diftérico y tetánico y vacuna contra la tos ferina (DTaP/DTP/Tdap/Td)²	4 dosis	5 dosis o 4 dosis si la cuarta dosis se aplicó a los 4 años de edad o más, o 3 dosis si tiene 7 años o más y la serie se inició a partir del año	3 dosis	
Refuerzo de la vacuna con toxoide diftérico y tetánico y la vacuna contra la tos ferina (Tdap) para adolescentes³	No corresponde		1 dosis	
Vacuna antipoliomielítica (IPV/OPV)⁴	3 dosis	4 dosis o 3 dosis si la tercera dosis se aplicó a los 4 años de edad o más		
Vacuna contra sarampión, paperas y rubéola (MMR)⁵	1 dosis	2 dosis		
Vacuna contra la hepatitis B⁶	3 dosis	3 dosis o 2 dosis de la vacuna contra la hepatitis B para adultos (Recombivax) para niños que recibieron las dosis en intervalos de al menos 4 meses entre los 11 y los 15 años de edad		
Vacuna contra la varicela⁷	1 dosis	2 dosis		
Vacuna antimeningocócica conjugada (MenACWY)⁸	No corresponde		7.º, 8.º, 9.º, 10.º y 11.º grado: 1 dosis	2 dosis o 1 dosis si la dosis se aplicó a los 16 años de edad o más
Vacuna conjugada contra Haemophilus influenzae tipo B (Hib)⁹	1 a 4 dosis	No corresponde		
Vacuna neumocócica conjugada (PCV)¹⁰	1 a 4 dosis	No corresponde		

- Una constancia serológica demostrada de anticuerpos contra el sarampión, las paperas o la rubéola o una confirmación de laboratorio de dichas enfermedades son pruebas aceptables de la inmunidad ante estas. Las pruebas serológicas para la poliomielitis son una prueba aceptable de la inmunidad solo si la prueba se hizo antes del 1 de septiembre de 2019 y los tres serotipos dieron positivo. Un análisis de sangre con resultado positivo para el anticuerpo de superficie contra la hepatitis B es una prueba aceptable de la inmunidad ante la hepatitis B. Una constancia serológica demostrada de anticuerpos contra la varicela, una confirmación de laboratorio de varicela o el diagnóstico de un médico, un asistente médico o un enfermero de práctica avanzada de que un niño tuvo varicela son pruebas aceptables de la inmunidad ante la varicela.
- Vacuna con toxoide diftérico y tetánico y tos ferina acelular (DTaP). (Edad mínima: 6 semanas)
 - Los niños que comienzan la serie a tiempo deben recibir una serie de 5 dosis de la vacuna DTaP a los 2 meses, 4 meses, 6 meses y entre los 15 y 18 meses de edad, y a los 4 años de edad o más. La cuarta dosis puede aplicarse a partir de los 12 meses de edad, siempre que hayan transcurrido por lo menos 6 meses desde la tercera dosis. Sin embargo, no es necesario que se repita la cuarta dosis de DTaP si se aplicó al menos 4 meses después de la tercera dosis de DTaP. La última dosis de la serie debe aplicarse a partir del cuarto año de edad y al menos 6 meses después de la dosis anterior.
 - Si la cuarta dosis de DTaP se aplicó a los 4 años de edad o más, y al menos 6 meses después de la tercera dosis, no se requiere la quinta dosis (de refuerzo) de la vacuna DTaP.
 - Para los niños nacidos antes del 1/1/2005, solo se requiere inmunidad a la difteria y las dosis de DT y Td pueden cumplir este requisito.
 - Los niños mayores de 7 años que no estén completamente vacunados con la serie de vacunas DTaP para niños deben recibir la vacuna Tdap como primera dosis de la serie de actualización; si se necesitan dosis adicionales, use la vacuna Td o Tdap. Si les aplicaron la primera dosis antes de su primer año de edad, deben aplicarse 4 dosis, siempre que la dosis final se aplique a los 4 años de edad o más. Si les aplicaron la primera dosis a partir de su primer año de edad, deben aplicarse 3 dosis, siempre que la dosis final se aplique a los 4 años o más.
- Refuerzo de la vacuna con toxoides tetánico y diftérico y de la vacuna contra la tos ferina acelular (Tdap) para adolescentes. (Edad mínima para 6.º, 7.º y 8.º grado: 10 años; edad mínima para 9.º a 12.º grado: 7 años)
 - Los estudiantes mayores de 11 años que ingresan a los grados de 6.º a 12.º deben recibir una dosis de Tdap.
 - Además del requisito para 6.º a 12.º grado, la vacuna Tdap también se puede aplicar como parte de la serie de vacunas de actualización para estudiantes mayores de 7 años que no estén totalmente vacunados con la serie de vacunas DTaP para niños, como se describió arriba. En el año escolar 2022-2023, solo las dosis de Tdap aplicadas a los 10 años o más cumplirán el requisito de Tdap para los estudiantes en los grados 6.º, 7.º y 8.º; sin embargo, las dosis de Tdap aplicadas a los 7 años o más cumplirán el requisito para los estudiantes en los grados 9.º a 12.º.
 - Los estudiantes que tienen 10 años de edad en 6.º grado y que aún no recibieron la vacuna Tdap cumplen los requisitos hasta que tengan 11 años.
- Vacuna antipoliomielítica inactivada (IPV) o vacuna antipoliomielítica oral (OPV). (Edad mínima: 6 semanas)
 - Los niños que comienzan la serie a tiempo deben recibir una serie de IPV a los 2 meses, 4 meses y entre los 6 y 18 meses de edad, y a los 4 años de edad o más. La última dosis de la serie debe aplicarse a partir del cuarto año de edad y al menos 6 meses después de la dosis anterior.
 - Para los estudiantes que recibieron la cuarta dosis antes de su cuarto año de edad y antes del 7 de agosto de 2010, es suficiente aplicar 4 dosis con al menos 4 semanas de diferencia.
 - Si la tercera dosis de la vacuna antipoliomielítica se aplicó a los 4 años de edad o más y por lo menos 6 meses después de la dosis anterior, no se requerirá la cuarta dosis.
 - Para los niños con antecedentes de OPV, solo la OPV trivalente (tOPV) se tiene en cuenta para los requisitos de la vacuna antipoliomielítica en las escuelas del Estado de Nueva York. Las dosis de OPV aplicadas antes del 1 de abril de 2016 deben incluirse a menos que se indiquen específicamente como monovalentes, bivalentes o como aplicadas durante una campaña de vacunación contra el virus de la poliomielitis. Las dosis de OPV aplicadas a partir del 1 de abril de 2016 no deben incluirse.
- Vacuna contra sarampión, paperas y rubéola (MMR). (Edad mínima: 12 meses)
 - La primera dosis de la vacuna MMR debe haberse aplicado a partir del primer año de edad. Para considerarse válida, la segunda dosis debe haberse aplicado al menos 28 días (4 semanas) después de la primera dosis.
 - Sarampión: Se necesita una dosis para prekindergarten. Se necesitan dos dosis para los grados de kindergarten hasta 12.º.
 - Paperas: Se necesita una dosis para prekindergarten. Se necesitan dos dosis para los grados de kindergarten hasta 12.º.
 - Rubéola: Se necesita por lo menos una dosis para todos los grados (prekindergarten hasta 12.º grado).
- Vacuna contra la hepatitis B
 - La primera dosis puede aplicarse al nacer o en cualquier momento después. La segunda dosis debe aplicarse al menos 4 semanas (28 días) después de la primera dosis. La tercera dosis debe aplicarse al menos 8 semanas después de la segunda dosis Y al menos 16 semanas después de la primera dosis, PERO no antes de las 24 semanas (cuando se apliquen 4 dosis, reemplazar “cuarta dosis” por “tercera dosis” en estos cálculos).
 - Dos dosis de la vacuna contra la hepatitis B para adultos (Recombivax) aplicadas con al menos 4 semanas de diferencia entre los 11 y 15 años cumplirán el requisito.
- Vacuna contra la varicela. (Edad mínima: 12 meses)
 - La primera dosis de la vacuna contra la varicela debe haberse aplicado a partir del primer año. Para considerarse válida, la segunda dosis debe haberse aplicado al menos 28 días (4 semanas) después de la primera dosis.
 - Para los niños menores de 13 años, el intervalo mínimo recomendado entre dosis es de 3 meses (si la segunda dosis se aplicó por lo menos 4 semanas después de la primera dosis, se puede aceptar como válida); para los mayores de 13 años, el intervalo mínimo es de 4 semanas.
- Vacuna antimeningocócica conjugada ACWY (MenACWY). (Edad mínima para 7.º, 8.º y 9.º grado: 10 años; edad mínima para 10.º a 12.º grado: 6 semanas)
 - Se requiere una dosis de la vacuna antimeningocócica conjugada (Menactra, Menveo o MenQuadfi) para los estudiantes que ingresan a los grados 7.º, 8.º, 9.º, 10.º y 11.º.
 - Para los estudiantes del 12.º grado, si la primera dosis de la vacuna antimeningocócica conjugada se aplicó a los 16 años o más, no se requiere la segunda dosis (de refuerzo).
 - La segunda dosis debe haberse aplicado a los 16 años o más. El intervalo mínimo entre dosis es de 8 semanas.
- Vacuna conjugada contra Haemophilus influenzae tipo b (Hib). (Edad mínima: 6 semanas)
 - Los niños que comienzan la serie a tiempo deben recibir la vacuna Hib a los 2 meses, 4 meses, 6 meses y entre los 12 y 15 meses de edad. Los niños mayores de 15 meses deben ponerse al día según el programa de actualización del ACIP. La dosis final debe aplicarse a partir de los 12 meses.
 - Si se aplicaron 2 dosis de vacuna antes de los 12 meses de edad, solo se requieren 3 dosis si la tercera dosis se aplica entre los 12 y 15 meses de edad y al menos 8 semanas después de la segunda dosis.
 - Si la primera dosis se recibió entre los 12 y 14 meses de edad, solo se requieren 2 dosis si la segunda dosis se aplicó al menos 8 semanas después de la primera dosis.
 - Si se aplicó la primera dosis a los 15 meses de edad o más, solo se requiere 1 dosis.
 - No se requiere la vacuna Hib para niños mayores de 5 años.
- Vacuna neumocócica conjugada (PCV). (Edad mínima: 6 semanas)
 - Los niños que comienzan la serie a tiempo deben recibir la vacuna PCV a los 2 meses, 4 meses, 6 meses y entre los 12 y 15 meses de edad. Los niños mayores de 15 meses deben ponerse al día según el programa de actualización del ACIP. La dosis final debe aplicarse a partir de los 12 meses.
 - Los niños no vacunados de 7 a 11 meses de edad deben recibir 2 dosis, con al menos 4 semanas de diferencia, seguidas de una tercera dosis entre los 12 y los 15 meses de edad.
 - Los niños no vacunados de 12 a 23 meses de edad deben recibir 2 dosis de la vacuna con al menos 8 semanas de diferencia.
 - Si se recibió una dosis de la vacuna a los 24 meses de edad o más, no se requieren dosis adicionales.
 - La PCV no es obligatoria para los niños mayores de 5 años.
 - Para tener más información, consulte la tabla de PCV que está en el Folleto de instrucciones para encuestas escolares, en: www.health.ny.gov/prevention/immunization/schools

Para obtener más información, comuníquese con:

**New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437**

**New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433**

2024-2025 学年

纽约州入学 / 就读疫苗接种要求¹

备注：
幼儿园学前班儿童应根据具体年龄接种相应疫苗。接种次数由免疫规范咨询委员会 (Advisory Committee on Immunization Practices, ACIP) 建议的计划决定。疫苗接种间隔应遵照 ACIP 建议的 0-18 岁人群免疫计划。最低年龄前接种或小于最短间隔接种的疫苗为无效接种，不计入以下接种次数。有关每种疫苗的具体信息，请参见脚注。未划分年级的儿童应根据其年龄所对应的年级进行免疫接种。

阅读剂量要求时务必参照本接种计划的脚注。

疫苗	幼儿园学前班 (托管班、早教班、托儿所或学前班)	幼儿园和 1、2、3、4、5 年级	6、7、8、9、10 和 11 年级	12 年级
白喉和破伤风类毒素疫苗和百日咳疫苗 (DTaP / DTP / Tdap / Td) ²	4 剂	5 剂或 4 剂 (只适用于第 4 剂在 4 岁或之后接种的情况) 或 3 剂 (只适用于年满 7 岁儿童并且第 1 剂是在 1 岁或以后接种的情况)	3 剂	
破伤风和白喉类毒素疫苗和百日咳疫苗青少年加强型 (Tdap) ³	不适用		1 剂	
脊髓灰质炎疫苗 (IPV / OPV) ⁴	3 剂	4 剂或 3 剂 (只适用于第 3 剂在 4 岁或之后接种的情况)		
麻疹、流行性腮腺炎及风疹 (MMR) 疫苗 ⁵	1 剂	2 剂		
乙肝疫苗 ⁶	3 剂	3 剂或 2 剂成人乙肝疫苗 (Recombivax) (只适用于疫苗在 11 岁至 15 岁之间接种，且两剂至少间隔 4 个月的情况)		
水痘疫苗 ⁷	1 剂	2 剂		
脑膜炎球菌结合疫苗 (MenACWY) ⁸	不适用		7、8、9、10 和 11 年级： 1 剂	2 剂或 1 剂 (只适用于疫苗在 16 岁或以后接种的情况)
乙型流感嗜血杆菌结合疫苗 (Hib) ⁹	1 至 4 剂	不适用		
肺炎链球菌结合疫苗 (PCV) ¹⁰	1 至 4 剂	不适用		

1. 经确认麻疹、腮腺炎、风疹抗体的血清学证据或相关化验确认结果都可以作为这些疾病的免疫证明。只有在 2019 年 9 月 1 日前进行脊髓灰质炎血清学检测，且三种血清型均为阳性时，脊髓灰质炎血清学检测才算是可接受的免疫证明。如果血液检查中乙肝表面抗体呈阳性，可作为乙肝的免疫证明。经确认水痘抗体的血清学证据、相关化验确认结果或者医师、助理医师或执业护士出具的儿童曾患水痘诊断书，都可以作为水痘的免疫证明。

2. 白喉、破伤风类毒素和无细胞百日咳 (DTaP) 疫苗。(最低年龄：6 周)

a. 按时开始接种该系列疫苗的儿童应在第 2 个月、第 4 个月、第 6 个月、15 至 18 个月之间以及 4 岁或以上时接种 5 剂 DTaP 系列疫苗。第四剂最早可于 12 个月时接种，但与第三剂之间应至少间隔 6 个月。如在接种第三剂 DTaP 至少 4 个月 after 接种了第四剂，则无需重复接种。此系列疫苗的最后剂必须在四岁或之后接种，且与前一剂疫苗的接种至少间隔 6 个月。

b. 如果第四剂 DTaP 是在 4 岁或之后接种，且与第 3 剂至少间隔 6 个月，则不需要接种第五剂（加强针）DTaP 疫苗。

c. 对于 2005 年 1 月 1 日前出生的儿童，只需要对白喉有免疫力，接种 DT 和 Td 即可满足这一要求。

d. 接种 DTaP 系列疫苗后未完全具备免疫力的 7 岁及以上儿童，应接种 Tdap 疫苗，作为追加疫苗系列的第一剂疫苗。如果需要额外接种疫苗，则使用 Td 或 Tdap 疫苗。如果在 1 岁前接种了第一剂疫苗，则需要 4 剂，只要最后一剂接种于 4 岁或之后。如果在 1 岁或之后接种了第一剂疫苗，则需要 3 剂，只要最后一剂接种于 4 岁或之后。

3. 白喉、破伤风类毒素和无细胞百日咳 (Tdap) 青少年加强型疫苗。(6、7 和 8 年级的最低年龄：10 岁；9 至 12 年级的最低年龄：7 岁)

a. 进入 6 年级至 12 年级的 11 岁或以上的学生必须接种一剂 Tdap。

b. 除了 6 至 12 年级的要求外，还可以将 Tdap 作为追加疫苗提供给 7 岁及以上未完全接种儿童 DTaP 系列疫苗的学生，如上所述。在 2022-2023 学年，只有 10 岁或以上学生接受的 Tdap 剂量才能满足 6、7 和 8 年级学生的 Tdap 要求；但是，7 岁或以上学生接受的 Tdap 剂量将满足 9 至 12 年级学生的 Tdap 要求。

c. 6 年级年满 10 岁且尚未接种 Tdap 疫苗的学生在到 11 岁前需要接种。

4. 灭活脊髓灰质炎疫苗 (IPV) 或口服脊髓灰质炎疫苗 (OPV)。(最低年龄：6 周)

a. 按时开始接种该系列疫苗的儿童应在第 2 个月、第 4 个月、6 至 18 个月之间以及 4 岁或之后接种 IPV 系列疫苗。该系列疫苗的最后剂必须在四岁或之后接种，且与前一剂疫苗的接种间隔至少为 6 个月。

b. 对于在 4 岁之前和 2010 年 8 月 7 日之前接受了第四剂的学生，4 剂之间间隔至少 4 周就足够。

c. 如果第 3 剂脊髓灰质炎疫苗是在 4 岁或之后接种，且与前一剂疫苗的接种间隔至少为 6 个月，则不需要接种第 4 剂脊髓灰质炎疫苗。

d. 对于有 OPV 记录的儿童，只有三价 OPV (tOPV) 符合纽约州学校脊髓灰质炎疫苗要求。除非特别注明为单价、二价或在脊髓灰质炎病毒免疫活动期间给予，否则应计算 2016 年 4 月 1 日之前给予的 OPV 剂量。在 2016 年 4 月 1 日及之后给予的 OPV 剂量不应计入。

5. 麻疹、腮腺炎及风疹 (MMR) 疫苗。(最低年龄：12 个月)

a. 必须在一岁或之后接种第一剂 MMR 疫苗。必须在第一剂 28 天（4 周）后接种第二剂疫苗才算有效接种。

b. 麻疹：学前班时需要接种一剂。从幼儿园到 12 年级需要接种两剂。

c. 腮腺炎：学前班时需要接种一剂。从幼儿园到 12 年级需要接种两剂。

d. 风疹：所有年级（学前班至 12 年级）至少需要一剂。

6. 乙型肝炎疫苗

a. 可在出生时或之后任何时间接种第 1 剂疫苗。第 2 剂必须在接种第 1 剂至少 4 周（28 天）后接种。第 3 剂必须在接种第 2 剂至少 8 周且接种第 1 剂至少 16 周后再接种，且接种年龄不得小于 24 周（当给予 4 剂时，在这些计算中用“4 剂”代替“3 剂”）。

b. 在 11 至 15 岁间接种两剂成人乙型肝炎疫苗 (Recombivax) 且两剂间隔时间至少为 4 个月的学生符合要求。

7. 水痘疫苗。(最低年龄：12 个月)

a. 必须在一岁或之后接种第一剂水痘疫苗。必须在第一剂 28 天（4 周）后接种第二剂疫苗才算有效接种。

b. 对于 13 岁以下的儿童，建议的接种最短间隔为 3 个月（如果第二剂的接种时间在第一剂后的至少 4 周，则可以视为有效）；对于 13 岁及以上的人，接种最短间隔为 4 周。

8. 脑膜炎球菌结合 ACWY 疫苗 (MenACWY)。(7、8 和 9 年级的最低年龄：10 岁；10 至 12 年级的最低年龄：6 周)。

a. 进入 7、8、9、10 和 11 年级的学生需要接种一剂脑膜炎球菌结合疫苗 (Menactra 或 Menveo)。

b. 对于 12 年级的学生，如果在 16 岁或之后接受了第一剂脑膜炎球菌结合疫苗，则不需要接种第二剂（加强剂）。

c. 第二剂必须在 16 岁或之后接种。接种最短间隔为 8 周。

9. 乙型流感嗜血杆菌 (Hib) 结合疫苗。(最低年龄：6 周)

a. 按时开始接种该系列疫苗的儿童应在第 2 个月、第 4 个月、第 6 个月和 12 至 15 个月之间接种 Hib 疫苗。超过 15 月龄的儿童必须按照 ACIP 的追加接种计划进行接种。最后一剂必须在 12 个月或之后接种。

b. 如果在 12 个月前接种了 2 剂疫苗，则仅需要 3 剂，第 3 剂需在 12 至 15 个月之间接种，且与第 2 剂至少间隔 8 周。

c. 如果第 1 剂是在 12 至 14 个月之间接种的，则仅需要 2 剂，第 1 剂与第 2 剂至少间隔 8 周。

d. 如果在 15 个月或之后接种了第 1 剂，则仅需要 1 剂。

e. 5 岁及以上儿童不需要接种 Hib 疫苗。

10. 肺炎链球菌结合型疫苗 (PCV)。(最低年龄：6 周)

a. 按时开始接种该系列疫苗的儿童应在第 2 个月、第 4 个月、第 6 个月和 12 至 15 个月之间接种 PCV 疫苗。超过 15 月龄的儿童必须按照 ACIP 的追加接种计划进行接种。最后一剂必须在 12 个月或之后接种。

b. 未接种疫苗的 7 至 11 月龄儿童需要先接种 2 剂，两剂至少间隔 4 周，然后再在 12 至 15 月龄之间接种第三剂。

c. 未接种疫苗的 12 至 23 个月大的儿童需要接种 2 剂疫苗，至少间隔 8 周。

d. 如果在 24 个月或之后接种了一剂疫苗，则不需要接种更多疫苗。

e. 5 岁及以上儿童不需要接种 PCV 疫苗。

f. 如需更多信息，请参阅《学校调查说明手册》里的 PCV 表格，网址为: www.health.ny.gov/prevention/immunization/schools

如需更多信息，请联系：

**New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437**

**New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433**

2491 (Simplified Chinese)

New York State Department of Health/Bureau of Immunization
health.ny.gov/immunization

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**GREAT NECK PUBLIC SCHOOLS
HEALTH SERVICES**

**DENTAL HEALTH REPORT
(ELEMENTARY SCHOOLS ONLY)**

Student's Name: _____ Date: _____

School: _____ Grade: _____

This is to certify that the student named above:

Is under my care for dental treatment: _____

Has completed dental treatment: _____

Name of Dentist: _____

Signature of Dentist: _____

Address: _____

This report should be returned to the school.