

# 2025-2026 School Year

## New York State Immunization Requirements for School Entrance/Attendance<sup>1</sup>

**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
<b>Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)<sup>2</sup></b>	<b>4 doses</b>	<b>5 doses or 4 doses</b> if the 4th dose was received at 4 years or older or <b>3 doses</b> if 7 years or older and the series was started at 1 year or older	<b>3 doses</b>	
<b>Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)<sup>3</sup></b>	<b>Not applicable</b>		<b>1 dose</b>	
<b>Polio vaccine (IPV/OPV)<sup>4</sup></b>	<b>3 doses</b>	<b>4 doses or 3 doses</b> if the 3rd dose was received at 4 years or older		
<b>Measles, Mumps and Rubella vaccine (MMR)<sup>5</sup></b>	<b>1 dose</b>	<b>2 doses</b>		
<b>Hepatitis B vaccine<sup>6</sup></b>	<b>3 doses</b>	<b>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</b>		
<b>Varicella (Chickenpox) vaccine<sup>7</sup></b>	<b>1 dose</b>	<b>2 doses</b>		
<b>Meningococcal conjugate vaccine (MenACWY)<sup>8</sup></b>	<b>Not applicable</b>		<b>Grades 7, 8, 9, 10 and 11: 1 dose</b>	<b>2 doses or 1 dose</b> if the dose was received at 16 years or older
<b>Haemophilus influenzae type b conjugate vaccine (Hib)<sup>9</sup></b>	<b>1 to 4 doses</b>	<b>Not applicable</b>		
<b>Pneumococcal Conjugate vaccine (PCV)<sup>10</sup></b>	<b>1 to 4 doses</b>	<b>Not applicable</b>		

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**

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

**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"/> <b>Allergies</b>	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> <b>Asthma</b>	<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"/> <b>Seizures</b>	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> <b>Diabetes</b>	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/m<sup>2</sup>

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

**Hyperlipidemia:**  Yes  Not Done

**Hypertension:**  Yes  Not Done

**PHYSICAL EXAMINATION/ASSESSMENT**

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

**Assessment/Abnormalities Noted/Recommendations:** \_\_\_\_\_ **Diagnoses/Problems (list)** \_\_\_\_\_ **ICD-10 Code\*** \_\_\_\_\_

**Additional Information Attached**

\*Required only for students with an IEP receiving Medicaid

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



**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 6<sup>th</sup> -12<sup>th</sup>}  
 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** {1<sup>st</sup> Dose Must be given on or After First Birthday. 2<sup>nd</sup> Dose Required for Kindergarten.}  
 MMR: 1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_  
 Or MEASLES: 1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_ MUMPS 1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_ RUBELLA 1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_
- ◆ **VARICELLA VACCINE (CHICKEN POX) → 2 Doses Required** {1<sup>st</sup> Dose Must be given on or After First Birthday. 2<sup>nd</sup> Dose Required for Kind., 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, 6<sup>th</sup>, 7<sup>th</sup>, 8<sup>th</sup>, 9<sup>th</sup>, 10<sup>th</sup> & 11<sup>th</sup> Grade}  
 1. \_\_\_/\_\_\_/\_\_\_ 2. \_\_\_/\_\_\_/\_\_\_ Or proof of Disease from Health Care Provider → DATE: 1. \_\_\_/\_\_\_/\_\_\_
- ◆ **MenACWY / Menactra / MCV4 / Menveo VACCINE → 1-2 Doses Required** {1<sup>st</sup> Dose Required for 7<sup>th</sup>, 8<sup>th</sup>, 9<sup>th</sup>, 10<sup>th</sup> & 11<sup>th</sup> Grade. 2<sup>nd</sup> Dose Required on or After Age 16, &/or Entering 12<sup>th</sup> 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: \_\_\_/\_\_\_/\_\_\_



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:
Month	Day	Year
		<input type="checkbox"/> Male
		<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
		<i>specify</i>	_____
	<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? \_\_\_\_\_

Month:    Day:    Year:

\_\_\_\_\_  
Signature of Parent or of Person in Parental Relation

\_\_\_\_\_  
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:

# 2025-2026 学年 纽约州入学 / 就读疫苗接种要求<sup>1</sup>

**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) <sup>2</sup>	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) <sup>3</sup>	不适用		1 剂	
脊髓灰质炎疫苗 (IPV / OPV) <sup>4</sup>	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 <sup>5</sup>	1 剂	2 剂		
乙肝疫苗 <sup>6</sup>	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 <sup>7</sup>	1 剂	2 剂		
脑膜炎球菌结合疫苗 (MenACWY) <sup>8</sup>	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) <sup>9</sup>	1 至 4 剂	不适用		
肺炎链球菌结合疫苗 (PCV) <sup>10</sup>	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 个月后又接种了第四剂，则无需重复接种。此系列疫苗的最后一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。该系列疫苗的最后一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](http://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**

# Año escolar 2025-2026

## Requisitos de vacunación del estado de Nueva York para inscribirse/asistir a la escuela<sup>1</sup>

**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
<b>Vacuna con toxoide diftérico y tetánico y vacuna contra la tos ferina (DTaP/DTP/Tdap/Td)<sup>2</sup></b>	<b>4 dosis</b>	<b>5 dosis o 4 dosis</b> si la cuarta dosis se aplicó a los 4 años de edad o más, o <b>3 dosis</b> si tiene 7 años o más y la serie se inició a partir del año	<b>3 dosis</b>	
<b>Refuerzo de la vacuna con toxoide diftérico y tetánico y la vacuna contra la tos ferina (Tdap) para adolescentes<sup>3</sup></b>	<b>No corresponde</b>		<b>1 dosis</b>	
<b>Vacuna antipoliomielítica (IPV/OPV)<sup>4</sup></b>	<b>3 dosis</b>	<b>4 dosis o 3 dosis</b> si la tercera dosis se aplicó a los 4 años de edad o más		
<b>Vacuna contra sarampión, paperas y rubéola (MMR)<sup>5</sup></b>	<b>1 dosis</b>	<b>2 dosis</b>		
<b>Vacuna contra la hepatitis B<sup>6</sup></b>	<b>3 dosis</b>	<b>3 dosis o 2 dosis</b> 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		
<b>Vacuna contra la varicela<sup>7</sup></b>	<b>1 dosis</b>	<b>2 dosis</b>		
<b>Vacuna antimeningocócica conjugada (MenACWY)<sup>8</sup></b>	<b>No corresponde</b>		<b>7.º, 8.º, 9.º, 10.º y 11.º grado: 1 dosis</b>	<b>2 dosis o 1 dosis</b> si la dosis se aplicó a los 16 años de edad o más
<b>Vacuna conjugada contra Haemophilus influenzae tipo B (Hib)<sup>9</sup></b>	<b>1 a 4 dosis</b>	<b>No corresponde</b>		
<b>Vacuna neumocócica conjugada (PCV)<sup>10</sup></b>	<b>1 a 4 dosis</b>	<b>No corresponde</b>		

1. 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.
2. Vacuna con toxoide diftérico y tetánico y tos ferina acelular (DTaP). (Edad mínima: 6 semanas)
  - a. 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.
  - b. 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.
  - c. 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.
  - d. 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.
3. 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)
  - a. Los estudiantes mayores de 11 años que ingresan a los grados de 6.º a 12.º deben recibir una dosis de Tdap.
  - b. 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.
  - c. 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.
4. Vacuna antipoliomielítica inactivada (IPV) o vacuna antipoliomielítica oral (OPV). (Edad mínima: 6 semanas)
  - a. 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.
  - b. 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.
  - c. 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.
  - d. 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.
5. Vacuna contra sarampión, paperas y rubéola (MMR). (Edad mínima: 12 meses)
  - a. 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.
  - b. Sarampión: Se necesita una dosis para prekindergarten. Se necesitan dos dosis para los grados de kindergarten hasta 12.º.
  - c. Paperas: Se necesita una dosis para prekindergarten. Se necesitan dos dosis para los grados de kindergarten hasta 12.º.
  - d. Rubéola: Se necesita por lo menos una dosis para todos los grados (prekindergarten hasta 12.º grado).
6. Vacuna contra la hepatitis B
  - a. 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).
  - b. 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.
7. Vacuna contra la varicela. (Edad mínima: 12 meses)
  - a. 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.
  - b. 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.
8. 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)
  - a. 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.
  - b. 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).
  - c. La segunda dosis debe haberse aplicado a los 16 años o más. El intervalo mínimo entre dosis es de 8 semanas.
9. Vacuna conjugada contra Haemophilus influenzae tipo b (Hib). (Edad mínima: 6 semanas)
  - a. 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.
  - b. 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.
  - c. 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.
  - d. Si se aplicó la primera dosis a los 15 meses de edad o más, solo se requiere 1 dosis.
  - e. No se requiere la vacuna Hib para niños mayores de 5 años.
10. Vacuna neumocócica conjugada (PCV). (Edad mínima: 6 semanas)
  - a. 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.
  - b. 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.
  - c. 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.
  - d. Si se recibió una dosis de la vacuna a los 24 meses de edad o más, no se requieren dosis adicionales.
  - e. La PCV no es obligatoria para los niños mayores de 5 años.
  - f. 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](http://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**

New York State Department of Health/Bureau of Immunization  
[health.ny.gov/immunization](http://health.ny.gov/immunization)

**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.***