NEWARK UNIFIED SCHOOL DISTRICT

Patient name: DOB:

Immunization History for School Enrollment (Signed by MD, PA, DO, NP Only)

Have your healthcare provider (***physician, physician assistant, or nurse practitioner***) verify dates and results from your records, fill out and sign this form. Submit it to the appropriate school personnel for verification and processing.

All dates must be in MM/DD/YYYY format

Required Vaccine	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose	Permanent Medical Exemption	Note For School Requirement
IPV/OPV (Polio)			Age: __yrs.			☐	4 doses meet TK/K-12 requirement, as do: 3 doses, if ≥1 dose given at age ≥4 years.
DTap/DTP - Age 0-6 yrs Tdap/Td - Age 7+ yrs (Diphtheria, Tetanus, Pertussis)			Age: __yrs.	Age: _ yrs.		☐	5 doses meet TK/K-12 requirement, as do: 4 doses, if ≥1 dose given at age ≥4 years; 3 doses, if ≥1 Tdap dose at age ≥7 years; Tdap dose may meet 7 th Grade requirement.
MMR (Measles, Mumps, Rubella)	Age: __mo.					☐	2 doses meet TK/K-12 requirement. Doses must be given at age ≥1 year.
Hib (Haemophilus influenzae type b)						☐	Required for pre-kindergarten only. At least 1 dose must be given at age ≥1 year
Hep B (Hepatitis B)						☐	3 doses meet TK/K–12 requirement.
VAR / VZV (Varicella/Chickenpox)						☐	2 doses meet TK/K–12 requirement.
Tdap – 7th Grade (Tetanus, Diphtheria, Pertussis)	Age: __yrs.					☐	1 dose given at age ≥7 years meets requirement for 7th grade advancement and 7 th–12th grade admission.

Clinician's Verification:

I hereby verify that the immunization history provided above is complete and accurate for the student named above.

Clinician Signature: _____ **Date signed:** _____

Print Name and Title: _____ **Office Stamp Required**

Address: _____

City/State/Zip _____

Telephone: _____