



RYE CITY SCHOOL DISTRICT
HEALTH CARE SERVICES
Rye, NY 10580

STUDENT IMMUNIZATION RECORD

STUDENT'S NAME _____ DATE OF BIRTH ____/____/____ SCHOOL _____

Public Health Law - Section 2164: All students enrolling in any school in New York State for the first time shall submit a written statement signed by a health care provider that they have been immunized as per NYS Standards. Exemptions from this requirement include: Serologic proof of immunity to Measles, Mumps, Rubella, Hepatitis B or Varicella; or medical exemptions approved by the district.

HEALTH CARE PROVIDER'S STATEMENT

DTaP/DTP (5 or *4 doses required): * If the 4th dose was received at 4 years or older and at least 6 months after previous dose, or 3 doses if 7 years or older and the series was started at 1 year or older.

1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____ *

Polio (4 or *3 doses of OPV/IPV required): * The 3rd dose in the series must be received on/or after age 4 years.

1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____

MMR (2 doses each Measles, Mumps & 1 dose of Rubella): The 1st dose must be received on/or after the first birthday. The 2nd dose must be received at least 28 days after the first dose.

1st _____ 2nd _____

Hepatitis B (3 doses): Dose 2 must be 4 weeks after dose 1. Dose 3 must be 8 weeks after dose 2 and 16 weeks after dose 1.

1st _____ 2nd _____ 3rd _____

Varicella (2 doses): The Center for Disease Control (CDC) recommends two doses of chicken pox vaccine: First dose must be received on/or after the first birthday. The second dose must be received at least 28 days after the first dose.

1st _____ 2nd _____

Tdap (1 dose): Required for all students entering grades 6 through 12. Minimum age is 10 years old.

1st _____

Meningococcal (2 doses): One dose required for all students entering grades 7, 8, 9, 10 & 11. Minimum age is 10 years old. Two doses required for all students entering grade 12 unless 1st dose administered at 16 years or older.

1st _____ 2nd _____

I hereby state, _____ has been immunized as documented above.
NAME OF CHILD

HEALTH CARE PROVIDER'S SIGNATURE: _____ DATE: _____

STAMP/LICENSE/ADDRESS/PHONE: _____