Revised 05/2015

VALLEY STREAM

UNION FREE SCHOOL DISTRICT THIRTEEN

CERTIFICATE OF IMMUNIZATION

Child's Name: _____ Date of Birth: _____

All incoming students must have a physical exam performed no more than twelve months prior to the start of the school year.

1.) DPT Vaccine 1. __/__/__ 2. __/__/__ 3. __/__/__
4. __/__/__ 5. __/__/__ 6.__/__/__

OR DTaP Vaccine 1.__/__/__ 2. __/__/__ 3. __/__/__ 4. __/__/__ 5. __/__/__

OR DTaP Vaccine 1.__/__/__ 2. __/__/__ 3. __/__/__ 4. __/__/__ 5. __/__/__

2.) Tdap Vaccine (For Sixth (6) Grade Entrance) (Effective Sept 2007) 1. __/__/__

3.) Polio (OPV) 1.__/__/__ 2. __/__/__ 3. __/__/__ 4. __/__/__ 5. __/__/__

OR IPV or e-IPV 1.__/__/__ 2. __/__/__ 3. __/__/__ 4. __/__/__ 5. __/__/__

4.) MMR Vaccine 1.__/__/__ 2. __/__/__

OR Measles 1.__/__/__ 2. __/__/__ Mumps 1.__/__/__ Rubella 1.__/__/__

5.) Hepatitis B 1.__/__/__ 2. __/__/__ 3. __/__/__

6.) Varicella Vaccine 1.__/__/__ 2. __/__/__
OR Disease __/__/__
OR Antibody Titler Level __/__/__ Results: _____

7.) HIB Vaccine 1.__/__/__ 2. __/__/__ 3. __/__/__ 4. __/__/__

8.) Lead Test __/__/__ Results: _____

9.) Mantoux Test __/__/__ Results: _____
OR Tine Test __/__/__ Results: _____

10.) Hepatitis A 1.__/__/__ 2. __/__/__

11.) Prevnar Vaccine 1.__/__/__ 2. __/__/__ 3. __/__/__ 4. __/__/__

Prescriber's name and title (please print): _____

Signature: _____ Date: _____

Address: _____ Phone Number: _____

Prescriber's Stamp: _____