

**Brookhaven Elementary School
Brookhaven, New York**

IMMUNIZATION FORM

Effective January 1, 1990 New York State law states that a child entering kindergarten must be immunized against polio, measles, German measles, mumps, and diphtheria before being allowed to enter school. **Effective August, 1994, New York State law states that all children born on or after January 1, 1993 and entering Kindergarten in September, 1998, will be required to have here (3) doses of Hepatitis B vaccine.** Under current regulations, it is the responsibility of the parent to provide medical proof of immunizations. For this reason, parents are asked to provide a medical doctor's certificate at the time of registration for school. The physician's signature on the bottom of this immunization statement will be accepted in place of the above certificate. On July 9, 1980, the revised regulations of Part 66, subchapter F of Chapter 11, Title 10 (Health) took effect and mandated that as of July 1, 1981 **no child shall enter or continue to attend school unless they can prove to the school authorities that they have:**

- Received three or more doses of diphtheria toxic vaccine.
- Received either three or more doses of trivalent oral poliovirus (TPOV), or four or more doses inactivated poliomyelitis vaccine (IPV) administered after 1968.
- Received two doses of live measles vaccine: The first dose given on or after the child's first birthday and the second on or after 15 months of age.
- Received a single dose of live rubella virus vaccine administered after the age of 12 months, or demonstrated serological evidence of rubella antibodies (physician's certificate of rubella disease is no longer sufficient)
- Received a single dose of live mumps virus vaccine administered after the age of 12 months, or had been diagnosed by a physician as having had mumps disease.
- Hib required for children ages 18 months to 5 years in daycare and pre-k program.
- Received a single dose of varicella vaccine after the age of 12 months.

_____ has completed the following immunization:

(Childs Name)	(Birthdate)		
Polio OPV (3Dates)	Diphtheria (DTP/DT) (3Dates)	MMR	Hepatitis B
_____	_____	#1 _____	#1 _____
_____	_____	#2 _____	#2 _____
_____	_____		#3 _____
Boosters	Boosters	Measles #1__ #2__	Variella _____
_____	_____	Mumps __	Rubella __ HIB Vaccine __
_____	_____		
Tuberculin Tine Test _____ PPD _____ Lead Screening (Pre-K-students) _____			

Signature of Physician
