

**MAMARONECK UNION FREE SCHOOL DISTRICT
VACCINATION ADMINISTRATION RECORD**

Please return this report to your **School Nurse** as soon as your child's vaccinations have been given and/or updated. Failure to provide acceptable evidence of immunizations within fourteen days of entry may lead to exclusion from school. This period may be extended up to thirty days for those transferring from out of state or abroad. Vaccines must follow the Advisory Committee for Immunization (ACIP) guidelines.

This form should be completed and/or updated annually. Please see the list of immunization requirements below:

NAME: _____ **DATE:** _____

DOB: _____ **GRADE:** _____ **TEACHER/COUNSELOR** _____

School: ☐ CEN ☐ CHAT ☐ MAS ☐ MUR ☐ HMX ☐ HS ☐ Other: _____

Immunization Requirements:

As required by NY State Dept. of Education, Health Care Provider verification of the following is needed for school attendance:

- **DTaP : three - five (3-5) doses** of diphtheria and tetanus toxoid-containing vaccine and acellular pertussis vaccine
- **Tdap : one (1)dose** - students 11 years of age or older entering grade 6 through 12 are required to have one dose of Tdap
- **IPV : three – four (3-4) doses** of polio vaccine
- **MMR : two (2) doses** of live measles, mumps and rubella vaccine (K-12)
- **HBV : three (3) doses** of Hepatitis B vaccine at intervals recommended by the ACIP (pre k – 12)
- **VARICELLA: – two (2) doses** of Varicella (chicken Pox) (K- 12)
- **MENINGOCOCCAL: one (1) dose** entering Grade 7,8,9,10 &11, one-**two (1-2) doses** at age 16, entering Grade 12

In addition, for pre-kindergartners:

- **Hib** Haemophilus influenzae type b vaccine: 1-4 doses
- **PCV** Pneumococcal conjugate (**PCV**) 1-4 doses (age appropriate)
- **MMR & Varicella** : one (1)dose

**VACCINATION ADMINISTRATION RECORD
TO BE COMPLETED & SIGNED BY THE HEALTH CARE PROVIDER**

<u>VACCINE</u>	<u>DATE GIVEN:</u>
DTaP 1 _____	DTaP 3 _____
DTaP 2 _____	DTaP 4 _____
DTaP 5 _____	OR...
DT 1 _____	OR Td 1 _____
DT 2 _____	OR Td 2 _____
DT 3 _____	OR Td 3 _____
Tdap _____	
IPV 1 _____	IPV 3 _____
IPV 2 _____	IPV 4 _____
VARICELLA 1 _____	
VARICELLA 2 _____	
MMR 1 _____	
MMR 2 _____	
TST (LAST) MANTOUX _____	RESULT _____ ❖
BCG _____	

❖ If Positive TST, Chest x-ray needed:
Date of CXR: _____ Results: _____

<u>VACCINE</u>	<u>DATE GIVEN:</u>
HEP B 1 _____	
HEP B 2 _____	
HEP B 3 _____	
OR (Adult formulation 2 dose series, ages 11 – 15 yrs)	
HEP B 1 (1.0 ML) _____	
HEP B 2 (1.0 ML) _____	
HIB 1 _____	
HIB 2 _____	
HIB 3 _____	
HIB 4 _____	
PNEUMOCOCCAL VACCINE	
1 _____	2 _____ 3 _____ 4 _____
MENINGOCOCCAL VACCINE _____	
MENINGOCOCCAL VACCINE _____	
HEP A 1 _____	HEP A 2 _____
HUMAN PAPILLOMAVIRUS VACCINE (HPV)	
1 _____	2 _____ 3 _____
OTHER _____	

OFFICE STAMP NECESSARY HERE ↓

Healthcare Provider
NAME (Print) _____
ADDRESS: _____
CITY/STATE/ZIP: _____

SIGNATURE: _____
TELEPHONE #: _____
DATE: _____