YONKERS PUBLIC SCHOOLS

CERTIFICATE OF IMMUNIZATION

NAME: _____ DOB: _____ Sex: Female Male

SCHOOL: _____ GRADE: _____

NY STATE LAW REQUIRES THAT ALL STUDENTS ATTENDING SCHOOL MUST MEET THE FOLLOWING IMMUNIZATION REQUIREMENTS. (highlighted)

Vaccine		Date/Vaccine type	Vaccine		Date/Vaccine type
Hepatitis B	1		**Measles Mumps Rubella**	1	
(e.g.: HepB, HepB-Hib,	2		(first measles **after** 12 mo old)	2	
DTaP-HepB-IPV)	3		**Varicella**	1	
Diptheria, Tetanus	1		(if > 12 years age)	2	
Pertussis	2		**Hepatitis A**	1	
(e.g.: DTaP, DT, DTaP-Hib,	3			2	
DTaP-HepB-IPV, Td)	4		**Influenza**	1	
Tdap				2	
Req. for entrance to 6-11th			**Other**		
Grades, born after 1/1/1994					
Polio	1				
(e.g.: IPV, DTaP-HepB-IPV)	2				
	3		**Pnuemococcal**	1	
			PreK - Born after 1/1/2008	2	
Haemophilius	1			3	
Influenza type b	2			4	
(PreK only)	3		**Meningococcal**		
	4				

Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also	check Chickenpox	History box	

Chickenpox History

☐ Check the box if this person has a Physician[-certified reliable history of chickenpox.

Reliable history may be based on:

- Physician interpretation of parent/guardian description of chickenpox
- Physical diagnosis of chickenpox, or
- Serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Physician/Practitioner Name: _____ **Date:** ____/____/____.

Signature _____.

Address: _____.

STAMP