ST. PAUL LUTHERAN PRESCHOOL IMMUNIZATION CERTIFICATE

Please return this form filled out and signed no later than the first day of school.

For your convenience, your Pediatrician's official immunization record may be substituted for this form. Their office can fax it directly to us at 716-692-3643.

STUDENT'S NAME:________________________DATE________________

GRADE (circle one): Preschool 3 year old Preschool 4 year old

STATE-MANDATED IMMUNIZATION RECORD

New York State Public Law 2164 requires HIB, polio, measles, Rubella (German) measles, mumps, Hepatitis B, Varicella, and diphtheria-pertussis-tetanus immunizations before a child can be admitted.

THIS IS TO CERTIFY THAT ____

(Student's last name) (First name) (Middle)

Address: ____________________________________ Birth Date: ______________

Phone No. ____________________________________

HAS RECEIVED the following MANDATED IMMUNIZATIONS: (list dates)

1. HAEMOPHILUS INFLUENZAE 1. __________ 2. __________ 3. ____________

TYPE B (HIB)

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2. ORAL POLIO (SABIN) 1. _____________ 2. ______________ 3. ____________

(3 doses mandated)

4. _____________ 5. _______________

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3. DIPTHERIA -PERTUSSIS-TETANUS (DPT) 1. _____________ 2. ______________

(4 doses mandated)

3. _____________ 4. _____________ 5. ______________

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4. MEASLES (RUBEOLA) 1. _____________ Date of Diagnosed Disease

(1 dose live measles administered on or after 12 months.) 2. _____________ ________________________

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5. MUMPS 1. ______________ Date of Diagnosed Disease

(1 dose live mumps administered on or after 12 months.) 2. _____________ _____________________

- over -

6. HEPATITIS B 1. ________________ 2. _______________ 3. _____________

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7. MEASLES (RUBELLA) 1. _______________ Date of Diagnosed Disease

(1 dose live Rubella

administered on or after 2. _______________ _______________________

12 months.)

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8. LEAD SCREENING 1. _________________

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9. VARICELLA (1 dose, serology, or MD DX) 1.___________________

*Date of Positive serology ________________________________

(Date of disease acceptable only if date of positive serology is indicated.)

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10. PNEUMOCOCCAL Vaccine (1-4 doses) 1._________________ 2. ________________

3. ________________ 4. ________________

**Physician's

Signature: __________________________________ Date: _________________________

Address: ____________________________________ Phone: _______________________

**Doctor's signature not required if official immunization record is presented to school.

(Doctor's booklet or signed Public Health Record or School Health Records.)

PLEASE RETURN THIS FORM TO THE CHURCH/PRESCHOOL OFFICE

AT ST. PAUL LUTHERAN CHURCH and PRESCHOOL

REVISED 1/2020