

MANHASSET SCHOOL DISTRICT
CERTIFICATE OF IMMUNIZATIONS

Name of Student _____ Date of Birth _____ Grade _____

New York State Education Law 2164, requires that before enrolling, students must present proof of immunizations against:

DIPHTHERIA, TETANUS, PERTUSSIS (DT, Dtap, Tdap), POLIO, HIB, MMR, HEPATITIS B, VARICELLA, MENINGITIS (Month, Day, Year)

Diphtheria (DTP) Series 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

DT 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Dtap 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Tdap 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Td 1. _____

Poliomyelitis (type)

Series **OPV** 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

IPV 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

HIB 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

MMR 1. Month _____ Day _____ Year _____

 2. Month _____ Day _____ Year _____

MEASLES 1. _____ 2. _____

MUMPS 1. _____ 2. _____

RUBELLA 1. _____ 2. _____

VARICELLA 1. _____

VARICELLA 2. _____

HEPATITIS B 1. Month _____ Day _____ Year _____

 2. Month _____ Day _____ Year _____

 3. Month _____ Day _____ Year _____

MENINGOCOCCAL A 1. _____ 2. _____

Signature of Physician _____ **Date** _____

Physician's Name (Please print) _____ **Phone #** _____

Physician's Address _____

Affix Physician's Office Stamp