**SOUTH HUNTINGTON SCHOOL DISTRICT**
**60 Weston Street, Huntington Station, New York 11746**

# CERTIFICATE OF IMMUNIZATION

**Name of Student:** _____
(Last Name) (First Name) (Middle Initial)

**Date of Birth:** _____ **School:** _____ **Grade:** _____

**Medical Exemption: Yes** _____ **No** _____ **Reason:** _____
(requires a doctor's note) _____

**REQUIRED IMMUNIZATIONS**

| | | | | | |
|---|---|---|---|---|---|
| **DTAP/DTP/Tdap** | #1 | #2 | #3 | #4 | #5 |
| **DT** | #1 | #2 | #3 | #4 | #5 |
| **Tdap** | #1 | | | | |
| **IPV/OPV** | #1 | #2 | #3 | #4 | #5 |
| **MMR** | #1 | #2 | | | |
| **Hepatitis B** | #1 | #2 | #3 | | |
| **Varicella** | #1 | #2 | | | |
| **Hib** | #1 | #2 | #3 | #4 | |
| **PCV** | #1 | #2 | #3 | #4 | |
| **Meningococcal (MenACWY)** | #1 | #2 | | | |
| **Meningococcal B** | #1 | #2 | #3 | | |

**Health Care Provider:**

**Print Name:** _____ **Stamp & Signature:** _____

**Address:** _____ **Date:** _____

_____ **Telephone:** _____

**RETURN THIS FORM TO THE SCHOOL NURSE**

2/7/19