# IMMUNIZATION HISTORY RECORD

**All dates must have the month, day and year.**
**Our computer system will not accept it without the day.**

OFF. CLASS: _____

OSIS# _____

_____ _____ _____
Last Name First Name D.O.B.: Mo./Day/Yr.

EXEMPT: (Documentation Must Be Attached) Medical_____

DPT or DT: _____ _____ _____ _____
Date Date Date Date/Tdap

POLIO: _____ _____ _____ _____
Date Date Date Date

*MEASLES: _____
Date

MUMPS: _____
Date

RUBELLA: _____
Date

**After First Birthday** - Second **MMR** _____
**Date**

HIB: _____ (Pre-K attendees only)
Date

PPD/MANTOUX _____ _____
Date Issued Date Read

Hepatitis B Vaccine 1st_____ 2nd_____ 3rd_____
Date Date Date

VARICELLA (CHICKEN POX) _____ _____
Date Date

MENINGOCOCCALL _____ _____
Date Date

Signature of Physician_____Date:_____

**Physician's Stamp:**
Name
Address
Telephone #
Registry #

*When appropriate medical documentation indicates that the student has the disease, WRITE in "M.D.D.X." (Medically documented disease history) and attach copy of documentation.

Second dose administered between ages 4 and 6.

# IMMUNIZATION DATES MUST BE COMPLETE

**ALL DATES MUST HAVE THE MONTH, DATE AND YEAR**

IF YOU HAVE ANY QUESTIONS,

PLEASE CONTACT MS. BULLOCK

AT STUYVESANT HIGH SCHOOLS MEDICAL OFFICE

212-312-4800 EXT. 3711

ABULLOCK@SCHOOLS.NYC.GOV