

**KENILWORTH PUBLIC SCHOOLS
SCHOOL ENTRANCE HEALTH FORM
Certification of Immunization**

To be completed by a physician, registered nurse, or health department official.

(A copy of the immunization record signed or stamped by a physician or designee indicating the dates of administration including month, day and year of the required vaccines shall be acceptable in lieu of recording of recording these dates on this form as long as the record is attached this form).
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name: _____ Date of Birth: /_____/_____/_____/

Last *First* *Middle* *Mo.* *Day* *Year*

IMMUNIZATION

RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN

*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6 th grade entry)	1	2	3	4	5
*Poliomyelitis (IPV, OPV)	1	2	3	4	5
*Haemophilus influenza Type b (Hib conjugate) *only children <60 months of age	1	2	3	4	5
*Pneumococcal (PCV conjugate) *only children <2 years of age	1	2	3	4	5
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV)	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children*.

Signature of Medical Provider or Health Department Official: _____ **Date (Mo., Day, Yr.):** ____/____/____