St. Thomas School

FORM A

Required Immunizations

St. Thomas the Apostle School Health Office . 42 Adams Place · Delmar, NY 12054 . (518)439-5573 Phone · 518-478-9773 fax

*Please ask your child's doctor to complete this form and sign below **or** attach a signed copy of the physician's immunization record.*

Preschool	Kdg.	Grades 1 – 5	Grade 6	Grade 7-12
DTaP/DPT – 4 doses **Tdap** – n/a **IPV/OPV** – 3 doses **MMR** – 1 dose **HepB** – 3 doses **Varicella** – 1 dose **Hib** – 1 dose **PCV** – 1-4 doses: 1 PCV13 dose (Age 4-5) **Lead Screening Blood Test**	**DTaP/DPT** – 4(5) doses: 5th dose needed if the 4th dose is given before age 4. **Tdap -** n/a **IPV/OPV** – 3(4) doses: 4th dose between age 4-6 yrs. **MMR** – 1 dose **HepB** – 3 doses **Varicella** – 2 doses **Hib** – n/a **PCV** – n/a	**DTaP/DPT** – 4(5) doses: 5th dose needed if the 4th dose is given before age 4. **Tdap** – (May have Tdap after age 7) **IPV/OPV** – 3 doses **MMR** – 2 doses: 2 doses by age 7. **HepB** – 3 doses **Varicella** – 1 dose **Hib** – n/a **PCV** – n/a	**DTaP/DPT** – 3 doses **Tdap** – 1 dose **IPV/OPV** – 4(3) doses: 4 doses if given in series. **MMR** - 2 doses **HepB** – 3 doses **Varicella** – 2 doses **Hib** – n/a **PCV** – n/a	**DTaP/DPT** – 3 doses **Tdap** – 1 dose **IPV/OPV** – 3 doses **MMR** – 2 doses **HepB** – 3 doses **Varicella** – 1 dose **Hib** – n/a **PCV** – n/a

St. Thomas the Apostle School requires proof of compliance with this law at the time you register your child. **Adequate proof** includes a **written certificate or record form the physician's office, a transcript from the previous school, or a certificate of religious or medical exemption.**

If the immunizations have not been completed by the date your child is to enter school, **we must exclude the child from school** until the immunizations have been completed or until proof of satisfactory progress toward the completion is shown. Please be advised that the law requires us to exclude children for up to two weeks if the process is not taking place and that, after two weeks of exclusion, we are required to notify Child Protective Services, a division of Albany County Department of Social Services.

Student Name (last, first):	**Date of Birth:**	**Grade Entering:**

Immunizations	Date	Date	Date	Date	Date
IPV/OPV	___/___/___	___/___/___	___/___/___	___/___/___	
DPT, DTaP	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Tdap	___/___/___	___/___/___			
Measles	___/___/___	___/___/___			
Mumps	___/___/___				
Rubella	___/___/___				
MMR	___/___/___	___/___/___			
Hepatitis B	___/___/___	___/___/___	___/___/___		
Varicella	___/___/___	___/___/___			
HIB	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Pneumococcal (PCV)	___/___/___	___/___/___	___/___/___	___/___/___	**PCV13** ___/___/___

History of Disease on: ___/___/___

Lead Screening Blood Test: Date _____ **Results:** _____

Physician's Signature:	**Date:**

Physician's Name/Stamp: