IMMUNIZATION RECORD

GARDEN CITY PUBLIC SCHOOLS

Health Services

56 Cathedral Avenue

Garden City, NY 11530

Student Name_____ Date of Birth_____

IMMUNIZATIONS: (Give full dates)

Measles: _____ _____ (History of disease :_____) (Presence of antibody:_____)

Rubella: _____ _____ (History of disease :_____) (Presence of antibody:_____)

Mumps: _____ _____ (History of disease:_____) (Presence of antibody:_____)

MMR: _____ _____

DPT: _____ _____ _____ _____ _____ _____

DTaP: _____ _____ _____ _____ _____ _____

DT/Td: _____ _____ _____ _____ _____ _____

Tdap _____ _____ _____ _____ _____ _____ _____

Polio: OPV _____ _____ _____ _____ _____ (Presence of antibody:_____)

IPV _____ _____ _____ _____ _____ (Presence of antibody:_____)

Hib: _____ _____ _____ _____ **Pneumococcal:** _____ _____ _____ _____

Hep B: _____ _____ _____ _____ (Presence of antibody:_____) **Hep A:** _____ _____ _____

Varicella: #1_____ #2 _____ (History of Disease: _____ or Presence of antibody_____)

Meningitis Vaccine (MCV4) #1_____ #2_____

HPV: _____ _____ _____ _____

Other (Please Specify): _____

Immunization requirements waived because of: (Give date) _____(Subject to the GCUFSD's approval)

A. Parent's religion_____ (Attach New York State required documentation)

B. Medical certificate_____ (Attach New York State required documentation)

**Issuing Medical Provider's Signature:_____

Name Printed or stamp:_____ _____

Title:_____

Date:_____

**NYS recognized providers: MD, DO, NP, PA

***The best school immunization record is a signed record from the Healthcare provider. A copy of the cumulative health record must be sent directly from the school.**