St. Thomas School

FORM A

Required Immunizations

Eff. 6/2019

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

DTaP – 4 doses
IPV – 3 doses
MMR – 1 dose
HepB – 3 doses
Varicella – 1 dose
Hib – 1- 4 doses
PCV – 1-4 doses

Tdap – n/a

Lead screening blood test

Grades K, 1, 2, 3, 4, 5

DTaP – 5 (4) doses: (unless the 4th dose is received at 4 years of age or older).
IPV – 4 (3) doses if 3rd dose received at 4 years of age or older
MMR – 2 doses
HepB – 3 doses
Varicella – 2 doses
Hib – n/a
PCV – n/a
Tdap - n/a

Grades 6, 7, 8, 9, 10, 11

DTaP – 3 doses
Tdap – 1 dose
IPV – 4 doses: (unless 3rd dose received at 4 years of age or older)

MMR - 2 doses
HepB – 3 doses
Varicella –2 doses

****Meningococcal Vaccine – 1 dose required for 7, 8, 9, 10**

Grade 12

DTaP – 3 doses
Tdap – 1 dose
IPV – 4 doses: (unless 3rd dose received at 4 years of age or older)

MMR – 2 doses
HepB – 3 doses
Varicella –1 dose

****Meningococcal Vaccine – 2 doses Or 1 dose if dose was received at 16 years of age or older**

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 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	___/___/___	___/___/___	___/___/___	___/___/___	____/____/___
DTaP	___/___/___	___/___/___	___/___/___	___/___/___	____/____/____
Tdap	___/___/___	___/___/___			
Measles	___/___/___	___/___/___			
Mumps	___/___/___	___/___/___			
Rubella	___/___/___				
MMR	___/___/___	___/___/___			
Hepatitis B	___/___/___	___/___/___	___/___/___		
Varicella	___/___/___	___/___/___	**History of Disease on:**		___/___/___
HIB	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Pneumococcal (PCV)	___/___/___	___/___/___	___/___/___	___/___/___	**PCV13** ___/___/___
Meningococcal	___/___/___	___/___/___			

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

Physician's Signature:	**Date:**

Physician's Name/Stamp: