CERTIFICATE OF IMMUNIZATION

Solomon Schechter School of Westchester

Student: _____ **School:** _____

Date of Birth: _____

Req. #			Dates Mo. Day Year	Remarks
4	D.P.T. (or Td or Dt)	1		
		2		
		3		
		4		
		5		
	Adult Dt or Td	1		
		2		
1	TdaP Boostrix/Adacel	1		
		2		
After Age 1 Year 2	M.M.R.	1		
		2		
	Childhood Diseases		Diagnosis	Date

Req. #			Dates Mo. Day Year	Remarks
3	Polio	1		
		2		
		3		
	Sabin / TOPV	4		
		5		
2	Meningitis	1		
		2		
3	Hepatitis B	1		
		2		
		3		
2	Varivax or Chicken Pox	1		
		2		

Other Vaccinations	Type	Date
	Hib _____	_____

Tuberculosis Test Not Indicated ☐

Tuberculosis Testing	Type	Date	Result
PPD			
BCG			
Chest X-Ray			

1. **Physician's Signature:** _____
   Print Name: _____
   Address: _____

2. **Legal requirements waived because:**
   _____ **Medical Exemption/Reason** **Date:** _____
   _____