



**Bethlehem Central
School District**
Office of the Registrar
90 Adams Place
Delmar, NY 12054
(518) 439-7481

REQUIRED IMMUNIZATIONS FORM

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

Public Health Law 2164 requires that the following immunizations be received prior to the child being allowed to enter school:

- 3 OPV or IPV (polio vaccine).**
- 3 DPT, DTaP, or DT (diphtheria-pertussis-tetanus vaccine). FULL DOSES ONLY.**
- 1 Tdap (Tetanus, Diphtheria, and Pertussis Booster)** for all children born on or after 01/01/94 who enroll in sixth grade
- 1 Measles vaccine (after first birthday).**
- 1 Mumps vaccine (after first birthday).**
- 1 Rubella vaccine (after first birthday).**
- 1 Measles booster (after 15 months)** for all children born on or after 01/01/1985.
- 3 Hepatitis B vaccine** for all children born on or after 01/01/1993 and all students entering seventh grade on or after September 2000.
- 1 Varicella vaccine (after first birthday)** for all children born on or after 01/01/1998 and all children born on or after 01/01/1994 who enroll in sixth grade, **or physician documentation regarding history of disease.**

The district needs proof of compliance with this law at the time you register your child into the school district. Adequate proof is written certificate or record from 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 this 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 which is a division of the Albany County Department of Social Services.

STUDENT'S NAME _____ **Date of Birth** _____

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE
OPV (3)	_/_/___	_/_/___	_/_/___	_/_/___	
IPV (3)	_/_/___	_/_/___	_/_/___	_/_/___	
DPT,DTaP	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___
DT	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___
Tdap	_/_/___				
Measles	_/_/___	_/_/___			
Mumps	_/_/___				
Rubella	_/_/___				
MMR	_/_/___	_/_/___			
Hepatitis B	_/_/___	_/_/___	_/_/___		
Varicella	_/_/___	History of Disease on		_/_/___	
HIB	_/_/___	_/_/___	_/_/___	_/_/___	
Other	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___

Physician's Signature _____ **Date** _____

Physician's name or stamp