9. RECORD OF IMMUNIZATIONS (SMR3)

All children between the ages of 2 and 18 years old must show proof of compliance with immunization requirements of Public Health Law Section 2164. The chart below summarizes the immunization requirements for school entrance/attendance from the NYS Department of Health.

Student Name: _____ Birthdate:_____ Grade entering _____

Parent/Guardian: This form is to be completed by your child's physician. The doctor may choose to attach a copy of your child's immunization history to this form **OR enter the MONTH, DAY, and YEAR for all vaccines your child received.** A child's immunization history must include all of the following vaccines to be considered fully immunized. Their immunization record should be evaluated according to the grade they are attending this school year.

Type of Vaccine	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
Required (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.)					
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT) • for children age 6 years and younger • final dose on or after age 4 years					5th dose not required if 4th dose was given on or after the 4th birthday
Tetanus and Diphtheria (Td) • for children age 7 years and older • 3 doses of Td required for children not up to date with DTaP, DTP, or DT series above					
Tetanus, Diphtheria and Pertussis (Tdap) • for children in 7th - 12th grade					
Polio (IPV, OPV) • final dose on or after age 4 years For children 4 years of age or older who have received less than 3 doses, a total of 3 doses are required. If both OPV and IPV were administered as part of a series, a total of 4 doses should be received, regardless of the child's current age.			If 4 or more doses were administered before age 4 years, an additional dose should be received on or after age 4 yrs.		
Measles, Mumps, and Rubella (MMR) • minimum age: on or after 1st birthday					
Hepatitis B (hep B)					
Varicella (chickenpox) • minimum age: on or after 1st birthday • vaccine or disease history required					

Note to Parents: The above schedule is the requirement for students who begin receiving their vaccines in infancy. There are different requirements for students who begin their vaccinations at a later age. If you have questions, please consult with your physician.

1 Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity tothese diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2 Immunization requirements updated as of April 2014. Please refer to http://www.health.ny.gov/prevention/immunization/schools/ for updated information and Frequently Asked Questions (FAQs).

8. PHYSICIAN MEDICAL RECORDS AND IMMUNIZATIONS (SMR2)

STUDENT NAME_____ Date:_____

SCREENINGS (to be completed by nurse or physician)

Height: _____ (%)	Weight: _____ (%)	Blood Pressure: _____ (%)

VISION	HEARING	SPEECH & LANGUAGE
Distance Acuity R_____ L_____	Audiometric Thresholds:	Speech Assessment: Yes No
Muscle Balance: Pass Fail N/A	Right Ear: Pass Fail N/A	Child has possible problem with:
Farsightedness: Pass Fail N/A	Left Ear: Pass Fail N/A	Voice: Yes No
Color: Pass Fail N/A	Other Tests (specify):	Articulation: Yes No
Child wears glasses? Yes No	Child wears hearing aid? Yes No	
Tested with glasses? Yes No	Tested with hearing aid? Yes No	
Referral made? Yes No	Referral made? Yes No	

EXAMINATIONS (to be completed by nurse or physician)

Head _____ Mouth_____ Genitalia_____ Lungs_____

Neck_____ Teeth_____ General Condition_____ Hernia_____

Nose_____ Abdomen_____ Orthopedic_____ Urinalysis_____

Throat_____ Heart_____ Nervous System_____

PHYSICIAN REMARKS & RECOMMENDATIONS

Physician Remarks & Recommendations:

This child is authorized to participate fully in:

- Classroom & academic activities Yes No
- Physical education classes Yes No

Specify any limitations

Physician Signature:

_____

Date:

_____

10. EXEMPTION TO STATE IMMUNIZATION LAW (SMR4)

Parents/Guardians

There are two exemptions that can be recognized for exemption to State Public Health Law *Section 2164*.

1. Medical Exemption: If the student's physician believes the immunizations are medically inadvisable for reason of medical contraindication, history of disease, or laboratory evidence of immunity, a written statement to that affect signed by the physician must be given to the school each school year. In the case of varicella disease, only history of the disease which was medically diagnosed will be accepted.

2. Religious Exemption: If you have a religious objection to immunizations, you, the parent must write a statement to the Head of School indicating your religious objections. You must provide such a letter each year your child is in school.

Please be aware that students who have a waiver of immunization either for medical or religious reasons will be excluded from school if there is an outbreak of a disease for which the student is not immunized.

I have read the requirements for immunization of my child for entry and attendance at school and agree to comply with New York State Public Health Law as explained above.

Parent Signature: _____ **Date:** _____

For Office Use Only	
Type of Exemption requested	
Medical	Statement received: Physician's Name_____ Date:_____
Religious	Parent Statement Received: Date:

11. STUDENT DENTAL REPORT (SMR5)

Parent/Guardian: This form should be given to your child's dentist to complete and return to you.

STUDENT DATA		
Last Name:	First Name:	MI:
Gender (circle): Male / Female	Birthdate:	

DENTIST INFORMATION			
Dentist Name:	Phone:	Fax:	
Address:	City:	State:	Zip:
Signature:	Date:		

The following SERVICES were performed:			The following ORAL HYGIENE instruction was provided:		
Examination	Yes	No	How to brush effectively	Yes	No
Diagnosis	Yes	No	How to floss	Yes	No
Radiographs	Yes	No	Dental health nutrition counseling	Yes	No
Oral Prophylaxis	Yes	No	How to use fluoride mouth rinse	Yes	No
Prescription for Fluoride Supplements	Yes	No			
Topical Application of Fluoride	Yes	No			

DENTIST'S COMMENTS

Dentist's Signature: _____ Date: _____