

Health Office  
 Our Lady of Mercy Academy  
 815 Convent Road  
 Syosset, NY 11791  
 516-921-1047

**SYOSSET CENTRAL SCHOOL DISTRICT**  
 Syosset, New York  
**CERTIFICATE OF NEW YORK STATE IMMUNIZATIONS**

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **GRADE:** \_\_\_\_\_ **SCHOOL:** \_\_\_\_\_

**IMMUNIZATION**      **MM/DD/YY**

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**\*\*DTaP/DTP**      1. \_\_\_\_\_  
                          2. \_\_\_\_\_  
                          3. \_\_\_\_\_  
                          4. \_\_\_\_\_  
                          5. \_\_\_\_\_

**\*\*MMR \***      1. \_\_\_\_\_  
                          **OR**      2. \_\_\_\_\_

**\*\*MEASLES \***      1. \_\_\_\_\_  
                          2. \_\_\_\_\_

Child had disease \_\_\_\_\_

**\*\*Td/DT**      1. \_\_\_\_\_  
                          2. \_\_\_\_\_

**\*\*MUMPS \***      1. \_\_\_\_\_  
                          Child had disease \_\_\_\_\_

**\*\*RUBELLA \***      1. \_\_\_\_\_  
                          Child had disease \_\_\_\_\_

**\*\*TdaP**      1. \_\_\_\_\_  
                          2. \_\_\_\_\_  
                          3. \_\_\_\_\_

**\*\*Varecella\*/**      1. \_\_\_\_\_  
                          **VARIVAX**      2. \_\_\_\_\_

Child had disease \_\_\_\_\_

**\*\*POLIO**      1. \_\_\_\_\_  
                          2. \_\_\_\_\_  
                          3. \_\_\_\_\_  
                          4. \_\_\_\_\_  
                          5. \_\_\_\_\_

**\*\*PCV/Prevnar**      1. \_\_\_\_\_  
                          2. \_\_\_\_\_  
                          3. \_\_\_\_\_  
                          4. \_\_\_\_\_

**\*\*Hib**      1. \_\_\_\_\_  
                          2. \_\_\_\_\_  
                          3. \_\_\_\_\_  
                          4. \_\_\_\_\_

**ROTOVIRUS**      1. \_\_\_\_\_

**MENACTRA/**      1. \_\_\_\_\_  
                          **MENOMUNE**

**\*\*Hepatitis B**      1. \_\_\_\_\_  
                          2. \_\_\_\_\_  
                          3. \_\_\_\_\_

**HPV/GARDASIL**      1. \_\_\_\_\_

**Hepatitis A**      1. \_\_\_\_\_  
                          2. \_\_\_\_\_

**OTHER** \_\_\_\_\_

**TB/PPD** \_\_\_\_\_ **RESULT** \_\_\_\_\_ **CHEST X-RAY** \_\_\_\_\_ **BCG** \_\_\_\_\_

**\*\* NYS Mandated**

**\* Please indicate if child had the disease**

**DATE** \_\_\_\_\_ **PHYSICIAN'S SIGNATURE** \_\_\_\_\_

**PHYSICIAN'S STAMP AND PHONE NUMBER** \_\_\_\_\_