# ABC Preschool Immunizations Form

Child's name: _____ Date of Birth _____

Address: _____

_____

Telephone #: _____

Parent's name's: _____

**In accordance with NYS Public Health Law, a certificate of immunization, signed by a physician and listing the dates of each inoculation, must be on file the first day of school.

| Record of immunization | | | |
|---|---|---|---|
| | Date Given: | Reaction: | Administered by: |
| Hepatitis B (Hep B) | | | |
| Rotavirus (RV) | | | |
| Diphtheria, Tetanus, Pertussis (DTP) | | | |
| H influenza type b (Hib) | | | |
| Varicella (Chickenpox) | | | |
| Polio (IPV) | | | |

| | | | |
|---|---|---|---|
| Measles, Mumps, Rubella (MMR) | | | |
| Hepatitis A (Hep A) | | | |
| Pneumococcal Conjugate (PCV) | | | |
| Influenza (Flu) | | | |
| Other | | | |

Legal requirements for immunizations waived because of:

A. Religious exemption (Attach written statement)
B. Physician's medical exemption (Attach statement of vaccines waived with physician's explanation, signature and date)
C. Vaccines waived due to temporary condition Y__ N__ if yes, date scheduled: _____

If your child has had any of the following diseases, please list date:
Chicken pox_____ Measles_____ German Measles _____
Mumps_____ Pneumonia _____ Polio _____
Rheumatic fever_____ Diabetes_____
Whooping cough_____ Epilepsy_____
Tuberculosis _____ Heart condition _____
Ear condition _____ Asthma/Allergy_____
Bladder condition _____

1. Has your child ever had any serious illness, injury or surgery within the past year? _____ if yes, explain and give dates _____
_____

2. Does your child have allergies? _____ If yes, please list them _____
3. Is your child taking medication on a regular basis? _____ if yes, please list _____
4. Has your child ever been treated for a psychological or emotional disorder? _____ if yes, please explain _____ _____
5. Any speech, hearing and/or vision difficulties? _____ If yes, please explain _____