

**KELLENBERG MEMORIAL HIGH SCHOOL**

1400 Glenn Curtiss Boulevard

Uniondale, NY 11553

Phone: (516) 292-0200

Fax: (516) 292-0877

**DOCUMENTED IMMUNIZATION DATES**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade in September 2018: \_\_\_\_\_

DPT, DTap: \_\_\_\_\_

Tdap Booster: \_\_\_\_\_ (students 11 yrs & older entering 6<sup>th</sup> grade)

POLIO: \_\_\_\_\_

MMR: #1 \_\_\_\_\_ #2 \_\_\_\_\_ or Titer \_\_\_\_\_

Hepatitis B: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Chicken Pox Vaccine #1 \_\_\_\_\_ #2 \_\_\_\_\_ or Health Provider Documented Disease \_\_\_\_\_

Hib: \_\_\_\_\_

Meningococcal Vaccine MEN ACWY: #1 \_\_\_\_\_ #2 \_\_\_\_\_ (students entering 7<sup>th</sup> and 12<sup>th</sup> grade)

**Physician's Signature:** \_\_\_\_\_ **Physician's Stamp:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**IN LIEU OF SUBMITTING THIS FORM, PARENTS MAY SUBMIT A PHYSICIAN'S PRINTOUT OF IMMUNIZATIONS RECEIVED. IF SUBMITTING A PRINTOUT, THE PRINTOUT SHOULD BE SIGNED AND STAMPED BY THE PHYSICIAN.**