

Dear Parents / Guardians,

All children entering or repeating 6<sup>th</sup> grade in September must have proof of the following immunizations, disease, blood test (serology) or medical deferment:

*One Varicella (Chicken Pox (Note: Two doses are recommended, but not yet required for school)*

*One Tetanus, Diphtheria, and Acellular Pertussis (Tdap) (Note: given as a booster vaccine)*

Please have your child's health care provider complete either the form below or the standard health appraisal form with immunizations and return it to the Health Office as soon as possible. Forms may be faxed, mailed to the school nurse, or hand delivered. Please keep a copy for your records. **YOUR CHILD MAY NOT ENTER SCHOOL IN SEPTEMBER WITHOUT PROOF.**

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**MEDICAL PROOF OF COMPLIANCE WITH PUBLIC HEALTH LAW**

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**Student's Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**PROVIDER:** Please complete the appropriate information which applies to this child with month, date, year of vaccine, disease, serology, or deferment. Note: you may defer Tdap on your patients who either had a Td within two years prior to entrance to sixth grade OR who are not yet 11 years old. If choosing to defer the vaccine, please indicate when you will be administering the vaccine, as the school must flag, track, and ensure vaccination occurs for those individuals.

**VARICELLA (Chicken Pox)**

- Varicella Vaccination (after one year of age\*) (Dates) 1) \_\_\_\_\_ 2) \_\_\_\_\_
- Varicella Disease on (Date) \_\_\_\_\_
- Varicella Blood Test (Date and result) \_\_\_\_\_  Positive  Negative

\*The New York State Education Department allows a maximum of a four day grace period prior to the first birthday

**TETANUS, DIPHTHERIA, AND ACELLULAR PERTUSSIS (Tdap)**

- Tdap (mo/day/year) \_\_\_\_\_
- Vaccine will be deferred until (mo/day/year) \_\_\_\_\_ because:
  - This child had a Td on or after 9/1/05 (specify mo/day/year of Td) \_\_\_\_\_
  - This child is not yet age 11, but is in process of completion of the series

**COMMENTS:**

\_\_\_\_\_  
**Physician's/NP's Name (print or stamp)**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Physician's/NP's Signature**

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

**STUDENT LEARNING IS THE GOAL**