MEDICAL REPORT/ IMMUNIZATION RECORD
KODOMONO KUNI, NY

Name of Child:	Date of Birth:	Date of Exam.

REQUIRED IMMUNIZATIONS

Immunization records are not valid without the month, day and year for each dose given.

Diphtheria, Tetanus, Perfussis (DtaP/DTP) 3 or more doses required	1st	2nd	3rd	4th	5th
Polio (OPV)(TOPV)(IPV)(eIPV) 3 or more doses required	1st	2nd	3rd	4th	5th
Hib (Haemophillus Influenza type B) Not applicable for K and up.	1st	2nd	3rd	4th	5th
MMR	1st	(2nd)			
or **Measles** Booster for entry into K required.	1st	(2nd)	(Measles Disease History)		
Mumps	1st	(2nd)	(Mumps Disease History)		
Rubella	1st	(2nd)	(Rubella Disease History)		
Varicella	1st		(Chicken Pox Disease History)		
Hepatitis B	1st	2nd	3rd		
PCV7 (Pneumococcal Conjugate Vaccine) PREVNAR Child born in or after Jan. 1, 2008	1st	2nd	**Medical Exemptions:** Due to physical condition of the above named child, immunization would endanger life or health of this child Yes ☐ No ☐		
Other Immunization (Specify)	1st	2nd			
Other Immunization (Specify)	1st	2nd			

Health Specifics	Comments
☐Yes ☐No Are there allergies?	
☐Yes ☐No Is medication regularly taken?	
☐Yes ☐No Is a special diet required?	

Notes: Exemptions from the requirements include:

1. **History of the above disease as documented by a physician licensed to practice medicine in the State of New York.**
2. **Serologic evidence of immunity to the disease.**
3. **A sincere and genuine religious belief.**

*** Parental recall of disease history is insufficient and will not be accepted as evidence of immunity**

On basis of my findings and on my knowledge of the above named child, I find that (s)he is free from contagious and communicable disease and is able to participate in any activities and programs.

Signature of Physician: _____

Date	Name and Address Stamp of Physician/Medical Service Provider