KELLENBERG MEMORIAL

P (516) 292-0200
F (516) 292-0877
W kellenberg.org

DOCUMENTED IMMUNIZATION DATES

Last Name: _____

First Name: _____

Date of Birth: _____ Grade in September 2026:_____

DPT, DTap: _____ _____ _____ _____ _____

Tdap Booster: _____ (students 11 yrs & older entering 6th 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 7th and 12th 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.