**LEXINGTON PUBLIC SCHOOLS**

**Lexington, Massachusetts**

Dear Parent/Guardian:

The immunization laws of the Commonwealth of Massachusetts require the following for entering Grades K-12 beginning in **August 2015.**

DTP/Td/DTaP A series of 5 doses, unless 4th dose given after age 4.

Tdap Required entering Grades 7-11, if it has been 5 years since last dose.

POLIO A series of 4 doses, unless 3rd dose given after age 4.

MMR (Measles, mumps, rubella) - 1st dose must be after age 1.

 Two doses required K-4; two doses required in 7ththrough 11h grade

MEASLES Two doses required.

 Disease - must submit laboratory evidence of immunity.

HEPATITIS B A series of 3 doses required to enter Grades K-12.

VARIVAX (Chicken Pox) Two doses required to enter Grade K-4; one dose required for

5-6; two doses required for entry into Grades 7-11; one dose for grade 12.

 Disease - verified by your doctor or nurse practitioner **in writing**.

**Please submit this form to your family physician to obtain written evidence of the required immunization(s).**

This completed form should be returned to the school nurse NO LATER THAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 Sincerely yours,

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 School Nurse

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**IMMUNIZATION CERTIFICATE**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_\_SCHOOL\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunization date(s) missing from this student’s health record are indicated below. Please supply the necessary dates **(month, day, and year)**.

  **1 2** **3 4 5 6**

**DTP/Td/DTaP \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_**

**Tdap booster** \_\_\_\_\_\_\_\_\_\_

**POLIO \_\_\_\_\_\_\_\_**  \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

**MMR \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_**

**HEPATIS B \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_**

**VARICELLA**

Vaccine \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

 Disease \_\_\_\_\_\_\_\_\_

**Tb-Mantoux \_\_\_\_\_\_\_\_**

**Other \_\_\_\_\_\_\_\_**

**Lead Screening ­­­­­­\_\_\_\_\_\_\_\_ Result** \_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Physician’s SignatureDate Telephone Number

Return to: