ARCHBISHOP MOLLOY HIGH SCHOOL

OFFICE OF THE SCHOOL NURSE

Dear Parent/Guardian,

All incoming students to Archbishop Molloy must have their immunizations completed as required by ***law*** per the ***New York State Health Department***.

- Immunizations – The enclosed immunization form or a copy of your immunizations from your physician must **state the immunization** with the **day, month**, and **year** the **vaccine** was **administered** and be stamped and signed by physician and **returned on Orientation/Registration day, March 3rd, 2018.**
- Student Physical – Your child does not have to have a physical at this time. **Physical should be done after June 1st – and is required before the first day of school.** Paperwork will be mailed home in May.

The immunizations required are the following:

- **DPT,** at least 4 doses for all New York City Schools.
- **Tdap** For all students
- **Oral Polio** 3 or more doses. **or**
- **Salk Vaccine** 4 or more doses.
- **Measles** 2 doses of the live vaccine after first birthday.
- **Rubella** 1 dose after the first birthday.
- **Mumps** 1 dose after the first birthday.
  (Immunization received before 1st birthday, no longer acceptable.)
- **Varicella** 1 dose on or after first birthday (or 2 doses separated by the minimum of 28 days for those immunized @ age 13 or older).
  2 doses of Varicella are recommended.
- **Hepatitis B** 3 doses or 2 doses of adult formulation of Merck "Recombivox HB" which must be documented as such and only for ages 11-15yrs
- **Meningococcal** a single dose of vaccine against meningococcal serogroups A,C,W-135 and Y should be administered to all adolescents at age 11 and 12 years (Brand names Menactra or Menveo)
  A second (booster) dose must be administered on or after age 16 years.

If the student has **acquired immunity** by having had the disease (Measles, Rubella, Mumps or Varicella (chicken pox) **documentation from a physician is necessary**. Please make copy for your records.

Thank you for your cooperation,
Mrs. Maria Gallagher RN

ARCHBISHOP MOLLOY HIGH SCHOOL

Student Name: _____

Date of Birth: _____ Male ___ Female ___

IMMUNIZATION *(Give full Dates)*

Measles: _____ _____ (History of disease:_____) (Presence of antibody:_____)

Rubella: _____ _____ (History of disease:_____)

Mumps: _____ _____ (History of disease:_____) (Presence of antibody:_____)

MMR: _____ _____

Polio: (TOPY< OPV _____ _____ _____ _____

(IPV< eIPV) _____ _____ _____ _____

Tetanus

(DPT; DTap; DT; Td:) _____ _____ _____ _____ _____

Tdap: _____ _____ _____ _____

Hib: _____ _____ _____ _____

Hep B: _____ _____ _____ _____

Hep A: _____ _____ _____ _____

Varicella: _____ _____ (Presence of disease: _____)

(Presence of antibody:_____)

Meningococcal: _____ _____

HPV: _____ _____ _____

Influenza: _____ _____ _____

Pneumococcal: _____ _____ _____

Other (Specify): _____ _____ _____

Physician's Signature: _____

Physician's Stamp: _____

This form or a copy of your immunizations from your physician stamped and signed, must be returned on registration day. Physical should be done after June 1st.