



HUNTINGTON HIGH SCHOOL
Health Office

CERTIFICATE OF IMMUNIZATION TRANSFER

Name: _____

Date of Birth: _____

Address: _____ Town: _____

Telephone: _____

REQUIRED BY NEW YORK STATE EDUCATION LAW AND NEW YORK STATE PUBLIC HEALTH LAW 2164 (Amended 8/94)

REQUIRED IMMUNIZATION

EXACT MONTH, DAY AND YEAR OF EACH IMMUNIZATION

DPT (3 Required)
DPT/DT BOOSTER
POLIO

1. _____ 2. _____ 3. _____ 4. _____

OPV, TOPV, eIPV (3 Required)
OR
IVP (4 Required)

1. _____ 2. _____ 3. _____ 4. _____
1. _____ 2. _____ 3. _____ 4. _____

MEASLES (2 Required)
(or Proof of Disease)

1. _____ 2. _____
Vaccine after Age 1

MUMPS (1 Required)
(or Proof of Disease)

1. _____
Vaccine After Age 1

Rubella (1 Required)
(Vaccine or Titer Test)

1. _____
Vaccine After Age 1

--OR MMR 1. _____ 2. _____
(2 Required After Age 1)

HAEMOPHILUS INFLUENZAE TYPE B (HIB) _____

HEPATITIS B (3 Required for K-12
(students born after 1/1/93)

1. _____ 2. _____ 3. _____

VARICELLA (required for students born after 1/1/98 – 1 dose) _____

School Nurse

Signature

Oakwood and McKay Roads Huntington, NY 11743
(631) 673-2105

Date