

**Smithtown Christian School**  
**IMMUNIZATION REQUIREMENTS FOR STUDENTS**  
**ENTERING GRADE 6 – Grade 12**

Dear Parent/Guardian,

The following immunizations are required by law for school attendance in New York State. No application will be processed without proof of immunization.

**Immunizations Required for Grade 6 through Grade 12:**

| Immunization                                       | Number of Doses |
|----------------------------------------------------|-----------------|
| Diphtheria/Tetanus/Pertussis                       | 3               |
| Tdap (Boostrix or Adacel)                          | 1 ****          |
| Polio (IPV/OPV)                                    | 3 – 4 *         |
| Measles/Mumps/Rubella (MMR)                        | 2 **            |
| Hepatitis B                                        | 3               |
| Varicella (Chicken Pox)                            | 2 **            |
| ***Gr. 7 - 12 only Meningitis (Menactra or Menveo) | 1 – 2 ***       |

(\*) Last dose of Polio to be given on or after fourth birthday.

(\*\*) First dose of MMR and Varicella to be given on or after first birthday.

(\*\*\*) First dose to be given after 10 years of age (Grade 7 - 8); First dose to be given after 6 weeks of age (Grades 9 – 12). Second dose to be given on or after 16<sup>th</sup> birthday (Grade 12).

(\*\*\*\*) Min. age 10 years (Grades 6-7); Min. age 7 years (Grades 8 – 12).

Please have your child's physician complete the form below and return it to the Health Office at Smithtown Christian School upon application for registration.

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Student's Name \_\_\_\_\_

DOB \_\_\_\_\_

DTP/DTaP #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

\*\*\*\*Tdap #1 \_\_\_\_\_

Polio #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

Measles/Mumps/Rubella (MMR) #1 \_\_\_\_\_ #2 \_\_\_\_\_

HepB #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Varicella #1 \_\_\_\_\_ #2 \_\_\_\_\_ or Date of Disease \_\_\_\_\_

\*\*\*Meningitis #1 \_\_\_\_\_ \*\*\*Meningitis #2 \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_ Physician's Stamp: