2025-26 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
All children must be age-appropriately immunized to attend school in New York State. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the "ACIP-Recommended Child and Adolescent Immunization Schedule." Doses received before the minimum age or intervals shown on the schedule are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in gradeless classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older and the series was started at less than 1 year of age or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]		**Not applicable**	**1 dose** given after age 10 years	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses or 2 doses** of **adult hepatitis B vaccine** (Recombivax) for children who received the doses at least 4 months apart and between the ages of 11 years through 15 years		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]		**Not applicable**	**Grades 7, 8, 9, 10 and 11: 1 dose**	**Grade 12: 2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

NYC Health | Department of Health and Mental Hygiene | Department of Education

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex	Date of Birth (Month/Day/Year)
			☐ Female ☐ Male	___ ___ / ___ ___ / ___ ___ ___ ___

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough	State	Zip Code	School/Center/Camp Name	District ___ Number ___ ___ ___	Phone Numbers
					Home _____ Cell _____ Work _____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name | Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs)

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs (list) _____

☐ Foods (list) _____

☐ Other (list) _____

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma (check severity and attach MAF): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes (attach MAF)
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis (latent infection or disease)
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
☐ ***Addendum attached.***

Medications (attach MAF if in-school medication needed)
☐ None ☐ Yes (list below)

PHYSICAL EXAM Date of Exam: ___ / ___ / ___

Height _____ cm (___ ___ %ile)
Weight _____ kg (___ ___ %ile)
BMI _____ kg/m² (___ ___ %ile)
Head Circumference (age ≤2 yrs) _____ cm (___ ___ %ile)
Blood Pressure (age ≥3 yrs) _____ / _____

General Appearance:

☐ Physical Exam WNL

NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl
☐	☐	Psychosocial Development	☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐ Abdomen
☐	☐	Language	☐	☐	Dental	☐	☐	Lungs	☐	☐ Genitourinary
☐	☐	Behavioral	☐	☐	Neck	☐	☐	Cardiovascular	☐	☐ Extremities

NI	Abnl	
☐	☐	Skin
☐	☐	Neurological
☐	☐	Back/spine

Describe abnormalities:

DEVELOPMENTAL (age 0-6 yrs)

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both
≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred
Dietary Restrictions ☐ None ☐ Yes (list below)

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment (at each well child exam, age 6 mo-6 yrs)	___/___/___	☐ At risk (do BLL) ☐ Not at risk
Child Care Only		
Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing	Date Done	Results
< 4 years: gross hearing	___/___/___	☐ NI ☐ Abnl ☐ Referred
OAE	___/___/___	☐ NI ☐ Abnl ☐ Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐ NI ☐ Abnl ☐ Referred

Vision	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ NI ☐ Abnl
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right _____ / _____ Left _____ / _____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay ☐ Yes ☐ No
Urgent need for dental referral (pain, swelling, infection) ☐ Yes ☐ No
Dental Visit within the past 12 months ☐ Yes ☐ No

CIR Number | Physician Confirmed History of Varicella Infection ☐ | Report only positive immunity:

IMMUNIZATIONS – DATES

														IgG Titers	Date
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___			Hepatitis B	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___			Measles	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Varicella	___/___/___	___/___/___			Mumps	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening ACWY	___/___/___	___/___/___			Rubella	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hep A	___/___/___	___/___/___			Varicella	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Rotavirus	___/___/___	___/___/___			Polio 1	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening B	___/___/___	___/___/___			Polio 2	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Other _____	___/___/___	___/___/___			Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** (list) — **ICD-10 Code**

_____ _____
_____ _____
_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (specify) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___ / ___ / ___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | Date Form Completed ___/___/___

DOHMH ONLY PRACTITIONER I.D.

Health Care Practitioner Name and Degree (print) | Practitioner License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ___/___/___ **I.D. NUMBER**

REVIEWER:

FORM ID#