

LEXINGTON PUBLIC SCHOOLS
Lexington, Massachusetts

Dear Parent/Guardian:

The immunization laws of the Commonwealth of Massachusetts require the following for entering Kindergarten beginning in **September 2007**.

- DTP A series of **5** doses, unless the 4th dose was given on or after the fourth birthday.
- POLIO A series of **4** doses, unless the 3rd dose was given on or after the 4th birthday.
- MMR (Measles, mumps, rubella) 2 doses- 1st dose must be at or after **1 year of age**.
- HEPATITIS B A series of **3** doses required to enter Grades K-12.

VARIVAX (Chicken Pox) One dose required after **1 year of age**.
 Disease - must be verified by your doctor **in writing**.

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

This completed form should be returned to the school nurse **NO LATER THAN**_____.

Sincerely yours,

 School Nurse

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
DTaP/Td	_____	_____	_____	_____	_____	_____
POLIO	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
HepB	_____	_____	_____	_____	_____	_____
Varicella	_____	_____	_____	_____	_____	_____
Vaccine	_____					
Disease	_____					
Tb-Mantoux	_____					
Other	_____					

Lead Screening _____ **Result** _____

Physical Exam within twelve months prior to entrance

Physician's Signature _____ Date _____ Telephone # _____

Return to: _____