Circle of Friends Preschool
1211 Manitou Road
Hilton, NY 14468
(585) 392-4010

Certificate of Immunization

_____ _____ _____ _____
Child's Last Name Child's First Name Birthdate Sex

_____ _____
Home Address Telephone

Required Immunizations	**1st**	**2nd**	**3rd**	**4th**	**5th**
DPT (DT) (3 or more)					
Polio (3 or more)					
Haemophilus influenza Type b**					
Measles (2 on or after first birthday)					
Rubella (1 on or after first birthday)					
Mumps (1 on or after first birthday)					
Hepatitis B (Series of 3)					
Varicella (1 dose)*					

**Series of 3 or 1 after 15 months of age

[ ] Immunization is completed as required by New York State Law (Dates included)
[ ] Immunization in process, to be completed by: _____
Date

_____ _____
Examining Physician Signature Date

_____ _____
Print Name of Examining Physician Address

I hereby agree to submit additional certification when immunization is complete. I understand that my child will be excluded from school if the school has not received full certification within ten school days of the date specified above by the examining physician.

_____ _____
Parent/Guardian Signature Date