

MENTOR CHRISTIAN SCHOOL
IMMUNIZATION REQUIREMENTS

(Please return form to school upon completion)

Child's Name _____ Date of Birth _____
Address _____ Phone Number _____
Parent's or Guardian's Name _____
Address _____ Physician _____

*Unless otherwise exempt, the OHIO STATE IMMUNIZATION LAW requires that all students entering school for the first time in Ohio in August 2010, shall be immunized as follows:

1. Poliomyelitis (OPV, IPV)
2. Diphtheria, Pertussis, Tetanus (DPT)
3. Measles, Mumps, Rubella (MMR)
4. Hepatitis B Vaccine
5. Varicella (Chicken Pox) for K 2010

REPORT OF IMMUNIZATIONS PUPIL HAS PREVIOUSLY RECEIVED

POLIOMYELITIS (OPV,IPV)

	Month	Day	Year
1 st dose	____/____/____		
2 nd dose	____/____/____		
3 rd dose	____/____/____		

POLIO BOOSTER

(Required if 3rd dose was _____ Date
received prior to age 4)

DIPHTHERIA, PERTUSSIS, TETANUS (DPT)

	Month	Day	Year
1 st injection	____/____/____		
2 nd injection	____/____/____		
3 rd injection	____/____/____		
4 th injection	____/____/____		

BOOSTER

(Required if 4th dose was _____ Date
received prior to age 4)

MEASLES, MUMPS, RUBELLA (MMR)

	Month	Day	Year
1 st injection (after age 1)	____/____/____		
2 nd injection (at least 28 days after 1 st dose but before K)	____/____/____		

HEPATITIS B VACCINE

	Month	Day	Year
1 st injection	____/____/____		
2 nd injection (at least 28 days after 1 st dose)	____/____/____		
3 rd injection (at least 2 mo. after 2 nd dose & at least 4 mo. after 1 st dose & at least 6 mo. of age)	____/____/____		

VARICELLA (Chicken Pox) VACCINE

	Month	Day	Year
1 st injection	____/____/____		
2 nd injection (required for K 2010 and following)	____/____/____		

Parent, Guardian, or Physician's Signature

Date

*Exceptions include pupils who present a wavier because of religious reasons or other reasons of "good cause" or pupils who present a written statement from their physician for a reason that is "medically contraindicated."