**School District Letterhead**

**Sample: Immunization Request Letter to Parents/Guardians of Students in PreK-12**

Dear Parent/Guardian of: (student name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**According to our records, your student is missing one or more immunizations (shots) for school.**

All students entering or attending school in NYS, including remote school attendance, must be age-appropriately immunized in accordance with the [NYSDOH Immunization Requirements for School Entrance/Attendance Chart.](https://www.health.ny.gov/publications/2370_2026.pdf) Please share this information with your student’s healthcare provider or local health department so that they can provide the immunizations (shots) or required proof.

**Please note: Each year, immunization requirements may change. Be sure to use the most current NYSDOH Immunization Requirements chart.**

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| **The following immunizations are needed:** |
| **Immunization Name** | **# of Doses Needed** |
| Diphtheria/Tetanus/Pertussis (DTaP or Tdap) |  |
| Polio |  |
| Measles/Mumps/Rubella (MMR) |  |
| Hepatitis B |  |
| Varicella (Chickenpox) |  |
| Meningococcal Conjugate (MenACWY) |  |
| Hemophilus Influenzae (HIB) |  |
| Pneumococcal Conjugate (PCV) |  |
| Tdap Booster |  |
| Notes: |
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| **Acceptable Proof of Immunization:** |
| **NYS Immunization Records** |
| An immunization certificate signed or stamped by your health care provider or health department. |
| An electronic health office record from your healthcare provider. |
| A record issued by NYSIIS or NYCIR. |
| **Out-of-State/Country/Previous School** |
| An official immunization registry from another state or an official record from a foreign country. |
| Unofficial records (from a private healthcare provider) must be reviewed and signed by a health practitioner licensed in NYS. |
| An official copy of the immunization record transferred directly from your child’s previous school, including the dates given. |
| **Blood tests/titers** |
| A blood test (titer) lab report showing a positive result for immunity to measles, mumps, rubella, varicella (chicken pox), or hepatitis B, signed by the healthcare provider. |
| A signed medical note verifying history of varicella (chicken pox) diagnosed by a physician, nurse practitioner, or physician assistant. |

**Immunizations are also available through the local health department at:**

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Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please return your student’s immunization record/documentation to the School Health Office.**

School Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_