Dear Parents:

If you have a child that will be eligible for the 2020-2021 Kindergarten school year, please complete the attached forms, both sides on two sided forms, and bring the completed forms with you during the registration period.

Kindergarten registration will be held Monday through Friday beginning March 2nd - March 27th, between the hours of 10:00am and 2:00pm. For those parents who are unable to register their child during the day we will have evening registration on Wednesday, March 18th, from 5:00pm - 7:00pm. Memorial School staff and the school nurse will be available to answer any questions you may have.

ELIGIBILITY REQUIREMENTS

1. If your child is five (5) years of age by August 31 of the forthcoming year, he/she is eligible.
2. "BIRTH CERTIFICATE" - Must be brought with you.
3. PROOF OF RESIDENCY - Current utility bill, or copy of lease.
4. PHYSICAL EXAMINATION INCLUDING VISION AND HEARING SCREENING BY YOUR PHYSICIAN MUST BE DATED AFTER AUGUST 31, 2019.
5. IMMUNIZATIONS - VERIFICATION WILL NEED TO BE PROVIDED BY THE END OF AUGUST. This must include lead screen results. Please see the other side for a list of needed vaccinations.

Each child MUST have a physical examination, and the attached form must be completed by your physician. A signed printout from your child’s doctor’s office listing all the required information is also acceptable.

No child will be admitted to Kindergarten without having met the eligibility requirements outlined on the reverse side of this form. We recommend calling your physician today to schedule an appointment as it sometimes takes several months to get one. All completed immunization/examination forms need to be in the School Nurse’s Office by August 28, 2020 before your child will be permitted to start school. These forms can be faxed by your doctor to the school at 978-297-3944.

This notification should help to remind you that preparation for Kindergarten entry will take time, effort, and planning on your part.

Teacher assignments will be made with the intention of creating balance among the Kindergarten classes. A Kindergarten Screening will be conducted, as required by State and Federal school laws. Screenings are scheduled for Wednesday, May 20th and Thursday, 21st.

We share the excitement of your child entering Kindergarten and look forward to both of you being a part of the Memorial School family. Please feel free to call the school at (978) 297-1305, with any questions or concerns you may have.
### Back to School Pup Says

<table>
<thead>
<tr>
<th>By Two Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 doses of Hep B</td>
</tr>
<tr>
<td>4 doses of DTaP</td>
</tr>
<tr>
<td>3 doses of Polio</td>
</tr>
<tr>
<td>3 or more doses of Hib</td>
</tr>
<tr>
<td>1 dose of MMR</td>
</tr>
<tr>
<td>1 dose of Varicella</td>
</tr>
</tbody>
</table>

**DTaP = Diphtheria, Tetanus, and Pertussis**

**Hib = Haemophilus influenzae type b**

**MMR = Measles, Mumps, and Rubella**

<table>
<thead>
<tr>
<th>By Kindergarten</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 doses of Hep B</td>
</tr>
<tr>
<td>5 doses of DTaP</td>
</tr>
<tr>
<td>4 doses of Polio</td>
</tr>
<tr>
<td>2 doses of MMR</td>
</tr>
<tr>
<td>2 doses of Varicella</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>By 7th Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 doses of Hep B</td>
</tr>
<tr>
<td>1 dose of Tdap</td>
</tr>
<tr>
<td>3 doses of Polio</td>
</tr>
<tr>
<td>2 doses of MMR</td>
</tr>
<tr>
<td>2 doses of Varicella</td>
</tr>
</tbody>
</table>

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**VACCINATE ALL YOUR CHILDREN**

For more information, contact your health care provider or the MDPH Immunization Program:

Massachusetts Department of Public Health Immunization Program
Main Number (617) 983-6800 or Toll-Free 888-658-2850

For BOSTON providers/schools only, you may call the Boston Health Commission: (617) 534-5611

Visit our Website at: [www.mass.gov/dph/imm](http://www.mass.gov/dph/imm)

Reviewed 7/2016
Student Information:

SASID:_________________________ LASID:_________________________ Male____ Female____

Last Name:_________________________ Current Grade:_________________________ Retained: no____ yes____ grade retained
First Name:_________________________ Home Phone:_________________________
Middle Name:_________________________ Date of Birth:_________________________
Country of Origin:_________________________

Home Address:_________________________
City/Town:_________________________
State & Zip:_________________________

Race: (check all that apply) American Indian or Alaska Native ______ Asian ______ Black or African American ______
Native Hawaiian or Other Pacific Islander ______ White ______

Ethnicity: Hispanic or Latino ______ Not Hispanic or Latino ______

Low Income Status: Eligible for free lunch (01) ______ Eligible for reduced lunch (02) ______

First Native Language:_________________________ Primary Language Spoken at home:_________________________
Child speaks and understands English fluently: yes____ no____ Secondary Language Spoken at home:_________________________
Child's parent/guardian speaks, reads and understands English fluently: yes____ no____

Parent/Guardian Information:

Parent/Guardian:_________________________
Address: (if different from above):_________________________
Home Phone:_________________________ Work Phone:_________________________ Cell Phone:_________________________
E-Mail Address:_________________________
Emergency Contact: (name, relationship and phone number):_________________________

Special Education Information:

Foster Placement: yes____ no____
Name of Social Worker & agency:_________________________ Phone:_________________________
Receiving any Special Educational Services: yes____ no____
If so, please specify:_________________________

Miscellaneous:

School Choice: yes____ no____
Previous School Attended:_________________________
Address:_________________________
City, State, Zip:_________________________

Additional Information Needed:

Date of Enrollment:_________________________
First Day of Attendance:_________________________
Homeroom Teacher:_________________________

Original form is to be maintained in the school office file. Copies should be sent to the following:

__________ Central Office _________ School Nurse _________ Special Education Office

Over
Home Language Survey

Massachusetts Department of Elementary and Secondary Education regulations require that all schools determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students. If a language other than English is spoken in the home, the District is required to do further assessment of your child. Please help us meet this important requirement by answering the following questions. Thank you for your assistance.

**Student Information**

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Gender</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Country of Birth</th>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>Date first enrolled in ANY U.S. school (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

**School Information**

<table>
<thead>
<tr>
<th>Start Date in New School (mm/dd/yyyy)</th>
<th>Name of Former School and Town</th>
<th>Current Grade</th>
</tr>
</thead>
</table>

**Questions for Parents/Guardians**

<table>
<thead>
<tr>
<th>What is the native language(s) of each parent/guardian? (circle one)</th>
<th>Which language(s) are spoken with your child? (include relatives -grandparents, uncles, aunts, etc. - and caregivers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(mother / father / guardian)</td>
<td>seldom / sometimes / often / always</td>
</tr>
<tr>
<td>(mother / father / guardian)</td>
<td>seldom / sometimes / often / always</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What language did your child first understand and speak?</th>
<th>Which language do you use most with your child?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Which other languages does your child know? (circle all that apply)</th>
<th>Which languages does your child use? (circle one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>speak / read / write</td>
<td>seldom / sometimes / often / always</td>
</tr>
<tr>
<td>speak / read / write</td>
<td>seldom / sometimes / often / always</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Will you require written information from school in your native language?</th>
<th>Will you require an interpreter/translator at Parent-Teacher meetings?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y / N</td>
<td>Y / N</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Signature:</th>
<th>Today's Date: (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>/20</td>
</tr>
</tbody>
</table>

**IF YOUR CHILD WILL NEED TRANSPORTATION FROM A “LICENSED DAY CARE CENTER,”**

Please answer the following questions:

1. **Name of Day Care Provider:**

2. **Address of Provider:**

3. **License Number of Provider:**

4. **Telephone Number of Provider:**
Kindergarten Registration: Parent Questionnaire

Child's Name: ___________________________  D.O.B. ___________________________

Teacher: ___________________________________  Date: _________________________

Your Name: ________________________________  Relationship to Child: ____________

Family History:
Child is living with:

Name  Relationship to Child  Age  School

Developmental History:
At what age did your child do the following?
Crawl ______  Walk ______  Speak first words ______  Begin to use sentences ______

Did your child babble as a baby? Yes____  No____
Does your child have difficulty climbing stairs? Yes____  No____
Does your child have difficulty running Yes____  No____

How are your child's eating habits? ____________________________________________

Please list any activities that your child does well ________________________________

What do you find most difficult about raising your child? _________________________

Medical History:
Has your child ever been hospitalized? Yes____  No____
If yes, why? ________________________________

Has your child ever had a high fever? Yes____  No____
Does your child have a history of ear infections? Yes____  No____  How many? ______

How were the infections treated? ______________________________________________

Please list any allergies your child has? _________________________________________

Has your child ever had a hearing evaluation Yes____  No____
Has your child ever had a vision examination Yes____  No____
Has your child ever been in a serious accident or fallen Yes____  No____

Please explain: ______________________________________________________________

Has your child ever lost consciousness? Yes____  No____

Please explain: ______________________________________________________________

Please describe any medical conditions that your child has:

OVER
Language:
What Language did the child hear as an infant?
What language does your child prefer to speak?
Does your child pronounce most sounds correctly? Yes____ No____
Does your child speak in complete sentences? Yes____ No____
Do your child's sentences make sense?

Education and Literacy:
Has your child been involved in Early Intervention? Yes____ Age started____ No____
What kind of services did he/she receive there?
Did your child attend preschool? Yes____ Where_____________ No____
How many days per week? _______ How many hours per day? _______
Did your child attend daycare? Yes____ Where_____________ No____
How often is your child read to? Love it____
How do you feel about reading? Like it-read 2 or 3 times a week____
Like it, but don't have time for it____
Bored by it____
Read only when necessary____
Have always struggled with it____

Please share any additional information or concerns about your child:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Has your child had PRIOR SCHOOL EXPERIENCE? Yes____ No____

Pre-School:
Public____ Private____ Where__________________________
How long in program____________________________

Head Start:
Yes ____ No ____ Where__________________________
How long in program____________________________

Day Care:
Yes ____ No ____ Where__________________________
How long in program____________________________

Other:

Additional comments:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Release of Information

I, ____________________________________________________________, authorize and request Memorial School to release and/or receive information regarding:

Student Name _______________________________________________ Date of Birth __________________________

To:

Name: _______________________________________________________

Address: _____________________________________________________

Phone: _______________________________________________________ 

This information may include any of the following unless otherwise indicated:

Psychological Evaluation/Testing Report, Education History/Status, Guidance Information/reports, and any other information that may be pertinent for the treatment of this child. This may also include Medical information to be shared between school and Physicians office; which can include Physicals, Immunizations, and medical testing.

*I understand that I may revoke this information at any time.*

Parent/Guardian Signature ______________________________________ Date ______________________________

School Personnel Signature/Title _________________________________ Date ______________________________

32 Elmwood Road, Winchendon, MA 01475 • Telephone 978-297-1305 • Fax 978-297-3944
February 2020

Dear Kindergarten Families,

On the back is a brief survey created by the DESE (Department of Elementary and Secondary Education). This survey is to help collect data on the accurate number of children who enter Kindergarten with one or more formal early childhood learning experiences. The DESE will use this data to inform districts and the state about the types of experiences children have before entering kindergarten, and more importantly to provide greater support for alignment of educational experiences for children from birth to grade 3.

Below are a few definitions to assist in filling out the brief survey:

**Coordinated Family and Community Engagement (CFCE) Services**: Locally based programs serving families with children birth through school age (Examples: Parent/Child Playgroups, Parent-child activities).

**Parent Child Home Program (PCHP)**: Home visiting model program funded by the Department of Early Education and Care. (Example: Do you have someone bring a toy/book to your home and model how to engage your child socially with the materials?)

**Licensed Family Childcare**: Refers to EEC (Department of Early Education and Care) licensed childcare in a group setting in a home. It may include care in the home of the family member, if the provider is both a relative and an EEC licensed childcare providing care to children from multiple families.

**Center-Based Care**: Refers to care for children in a group setting, including public and private Preschools. Head Start, day care centers, and integrated public preschools.

Thank you in advance for taking the time to fill out and return this survey. Please feel free to call should you have any questions.

Sincerely,

Michelle Atter
Principal
Early Childhood Education Experience Survey

Please check next to the option that best describes your child's preschool experience in the school year prior to entering Kindergarten. **Select one option only, and indicate hours where applicable.** Thank you!

Name of child: ___________________________ Date of Birth: ________________

_____ My child did not have any formal early childhood program experience

_____ My child did not have formal early childhood program experience but participated in Coordinated Family and Community Engagement (CFCE) services.

_____ My child did not have formal early childhood program experience but participated in Parent Child Home Program (PCHP) services.

_____ My child did not have formal early childhood program experience but participated in **BOTH** Coordinated Family and Community Engagement (CFCE) **AND** Parent Child Home Program (PCHP) services.

My child attended a Licensed Family Child Care Provider (indicate hours below)

_____ for less than 20 hours per week

_____ for 20+ hours per week

My child attended a Center Based Program (indicate hours below)

_____ for less than 20 hours per week

_____ for 20+ hours per week

My child attended **BOTH** a Licensed Family Child Care Provider **AND** a Center Based Program (indicate hours below)

_____ for less than 20 hours per week

_____ for 20+ hours per week
Dear Kindergarten Parent:

Attached you will find a copy of the Winchendon Public School District's Policy on Student Transportation Services. Please read the policy to become familiar with the portion that relates to kindergarten transportation.

If you have another child that is already being transported home on the same bus as your kindergarten child and you would like them to depart the bus together please complete the form below. If you intend to have your kindergarten child depart the bus with a child that attends child care with him/her, the school must be given written permission from that child's parent. As per the policy, if a parent is not at their kindergarten child's designated stop, the child will be returned to Memorial School and the parent will be expected to pick the child up there.

Remember, this policy is for your child's safety. If the policy is not adhered to the student's riding privileges may be revoked and the parent may be responsible for transporting their kindergarten child for the remainder of the school year.

All parents need to complete Section A of the form below. If Part B is applicable, please complete and indicate any student already on their bus that will be responsible for walking with them from their bus stop. Return form to the Memorial School office by your child's first day of school or he/she will not be allowed to exit the bus at their stop. You will be called by Memorial School personnel to come to the school to pick him/her up.

A. I have read and understand the "Student Transportation Services Policy".

Name of Kindergarten child (please print):

Name of Parent/Guardian (please print):

Daytime Phone: __________________________ Extension:

B. I have another child/children who already rides the same bus as my kindergarten student who will get off at their designated bus stop (please list name and grade).

Name(s) of student(s) your child may depart the bus with (please print). If a child listed below is not a sibling, a permission note from their parent must be attached:

Grade:

Grade:

Grade:

Signature of Parent/Guardian: __________________________ Date __________
STUDENT TRANSPORTATION SERVICES

In Accordance with policy EEA, Student Transportation Services, the following guidelines have been established.

1. All resident pupils in Kindergarten, except those residing in the immediate vicinity of the school, shall be provided transportation. Resident pupils in grade 1-6 living beyond one mile from the school attended shall be provided transportation. Resident pupils in grades 7-12 living beyond one and one-half miles from the school they attend shall be provided transportation.

2. All bus routes and designated bus stops will be determined by the Superintendent of Schools or his/her designee. Any requests for bus stop changes shall be made in writing to the Superintendent of Schools stating the reason for said request.

3. Those students who attend Child Care beyond one (1) mile (grades 1-6) or one and one-half (1½) miles (grades 7-12) will be eligible for transportation based on space available. These students will be expected to walk to the nearest designated bus stop.

4. Kindergarten students will be picked up by the bus at a designated bus stop as near as possible to the student’s home or childcare facility and will not walk more than one-half (1/2) mile to a designated bus stop.

5. Students in grades 1-12 who are being transported to and from their home or childcare facility shall not be required to walk more than one (1) mile to a designated bus stop.

6. As a general guideline, students should spend no more than forty-five (45) minutes on the bus to or from school, with the exception of the wait time at schools for pickup and drop off.

7. There shall be no standees allowed on Winchendon buses.

8. Bus capacity, K-6, shall not exceed 64 students; 7-12 shall not exceed 45 students.

9. Department of Education regulations do not make provisions for the transportation of school choice students. However, school choice students may be accommodated if seats are available on the specific bus route in question and parents can make arrangements to meet the bus at a convenient Winchendon stop.
10. A parent or responsible designee must meet kindergarten students at the designated bus stops at the end of the session. A bus driver may let a kindergarten student off the bus if the parent or responsible designee is clearly visible and identifiable by the student and/or the bus driver, but cannot come out to the bus due to supervisory responsibilities or disability. If the parent or responsible designee is not at the bus stop, nor clearly visible and identifiable by the student and/or the bus driver, the driver will return the kindergarten student to school. If there is any uncertainty by the bus driver, the child will be returned to school at the end of the route, for the safety of the child. The bus company will notify the school if a child is being returned.

11. When the parent or designee fails to meet the child at the bus stop, the following procedures will result.

A. First Occasion: The child will be returned to school and the parents notified by telephone that future failure to meet their child will result in the loss of bus privilege from school after the third time.

B. Second Occasion: The child will be returned to school and the parents receive a verbal and a written warning of the loss of bus privilege leaving school after the third occasion.

C. Third Occasion: The child will be returned to school and the parents will be informed of the loss of the bus privilege for the trip leaving from school and that they must pick the child up at school at the dismissal time for the future. Failure to do so will result in school personnel notifying the police and DSS of potential negligence on the part of the parent(s).

Revised 10/26/07

First Reading - November 1, 2007
Second Reading - November 15, 2007
Adopted by School Committee - November 15, 2007
Name: ____________________________ Male □ Female □ Date of Birth: ____________________________

Medical History

Pertinent Family History

Current Health Issues

Y □ N □ Allergies: Please list: ____________ Medications ____________ Food ____________ Other ____________

History of Anaphylaxis to ____________ Epi-Pen®: □ Yes □ No

□ Asthma: ____________ Asthma Action Plan □ Yes □ No (Please attach)

□ Diabetes: □ Type I □ Type II

□ Seizure disorder: ____________

□ Other (Please specify) ____________

Current Medications (if relevant to the student's health and safety) Please circle those administered in school; a separate medication order form is needed for each medication administered in school.

Physical Examination


(Check = Normal / If abnormal, please describe.)

□ General □ Lungs □ Extremities □ Skin □ Heart □ Neurologic □ HEENT □ Abdomen □ Other □ Dental/oral □ Genitalia

Screening: (Pass) (Fail) (Pass) (Fail) (Pass) (Fail)

Vision: Right Eye □ □ Hearing: Right Ear □ □ Postural Screening: □ □

Left Eye □ □ Left Ear □ □ (Scoliosis/Kyphosis/Lordosis)

Stereopsis □ □

Laboratory Results: □ Lead Date □ Other ____________

The entire examination was normal: □

Targeted TB Skin Testing: □ Med-to-High risk (exposure to TB: born, lived, travel to TB endemic countries; medical risk factors): □ Low risk (no TB test done)

TB Test Type: □ TST □ IGRA Date: ____________ Result: □ Positive □ Negative □ Indeterminate/Borderline

Referred for evaluation to: ____________ Date: ____________

This student has the following problems that may impact his/her educational experience:

□ Vision □ Hearing □ Speech/Language □ Fine/Gross Motor Deficit

□ Emotional/Social □ Behavior □ Other □ Other

Comments/Recommendations:

□ Y □ N This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:

□ Y □ N Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.

Signature of Examiner Circle: MD, DO, NP, PA Date ____________ Please print name of Examiner.

Group Practice Telephone ____________

Address City State Zip Code _______ _______ _______ 

Please attach additional information as needed for the health and safety of the student. MDPH 07/11/18
**CERTIFICATE OF IMMUNIZATION**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date</th>
<th>Vaccine Type</th>
<th>Date</th>
<th>Vaccine Type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>(e.g., HepB, Hep B-CpG, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)</td>
<td>2</td>
<td>Measles, Mumps, Rubella (e.g., MMR, MMRV)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diphtheria, Tetanus, Pertussis</strong></td>
<td>1</td>
<td></td>
<td>1</td>
<td>Meningococcal Quadrivalent</td>
</tr>
<tr>
<td>(e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)</td>
<td>2</td>
<td>MenACWY-Conjugate (MCV4) or Polysaccharide (MPSV4)</td>
<td>2</td>
<td></td>
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<td>3</td>
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<tr>
<td></td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Haemophilus influenzae type b</strong></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
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<tr>
<td></td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Polio</strong></td>
<td>1</td>
<td></td>
<td>1</td>
<td>2009 H1N1 Influenza Inactivated or Live</td>
</tr>
<tr>
<td>(e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)</td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
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<td>4</td>
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<td></td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pneumococcal Conjugate</strong></td>
<td>1</td>
<td></td>
<td>1</td>
<td>Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)</td>
</tr>
<tr>
<td>(PCV13, PCV7)</td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
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<td></td>
<td>3</td>
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<td>1</td>
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<tr>
<td></td>
<td>4</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Rotavirus</strong></td>
<td>1</td>
<td></td>
<td>1</td>
<td>Zoster (Shingles)</td>
</tr>
<tr>
<td>(e.g., RV5: 3-dose series, RV1: 2-dose series)</td>
<td>2</td>
<td></td>
<td>1</td>
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<tr>
<td></td>
<td>3</td>
<td></td>
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</tbody>
</table>

Please indicate vaccine type (e.g., DTaP-Hib, etc.), not brand name.

Please see next page ➔
CERTIFICATE OF IMMUNIZATION (continued)

Please indicate vaccine type (e.g., DTaP-Hib, etc.), not brand name.

Other Vaccines:

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Dose No.</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

Serologic Evidence of Immunity

<table>
<thead>
<tr>
<th>Test (if done)</th>
<th>Date of Test</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>/ /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>/ /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>/ /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella*</td>
<td>/ /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>/ /</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Must also check Chickenpox History box.

Chickenpox History

- Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:
- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic evidence of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)*:

Signature:

Facility name:

Massachusetts Department of Public Health 9/19