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Mayor

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**ESP Immunization Record – Students & Staff Under the Age of 18**

In accordance with state regulation, ESP will maintain an immunization record for each student, as well as for all staff members, who are under the age of 18.

**Required Immunizations**

All students and full time staff members under the age of 18 must supply the following written documentation of immunization or alternate proof of immunity:

1. Measles, Mumps, and Rubella (MMR) Vaccine. At least one dose of MMR vaccine(s) at or after 12 months of age or there must be proof of laboratory evidence of immunity;
2. Polio Vaccine: At least three doses of either trivalent oral polio vaccine (OPV) or enhanced potency inactivated polio vaccine (e-IPV) are required. If a mixed schedule of polio vaccine is given (IVP and OPV), a total of four doses is required;
3. Diphtheria and Tetanus Toxoids and Pertussis Vaccine: At least four doses of DTaP/DTP/DT/Td are required. (The Pertussis component is not given to anyone seven years of age or older). A booster dose of tetanus/diphtheria, adult-type toxoid (Td) is required if more than ten years have elapsed since the last dose;
4. Hepatitis B: For anyone born on or after January 1, 1992 three doses of Hepatitis B vaccine are required.

Student/Staff Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Tel. Number: \_\_\_\_\_

Name(s) of Student's/Staff's Parent(s)  
or Guardians: \_\_\_\_\_

Address of Student's/Staff's Parent(s)  
or Guardians: \_\_\_\_\_

Tel. No. of Student's/Staff's Parent(s)  
or Guardians: \_\_\_\_\_

Student's/Staff's Date of Birth: \_\_\_\_\_

Itemized List of Immunizations in Accordance with Requirements:

_____	_____
_____	_____
_____	_____



9. Is your child taking any medication? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes

NAME OF MEDICATION \_\_\_\_\_

REASON \_\_\_\_\_

DOSAGE \_\_\_\_\_

TIME/S AND HOW TO BE TAKEN \_\_\_\_\_

10. Does your child have a history of allergies? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, please explain. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. Is your child allergic to bees? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, to what extent? \_\_\_\_\_

\_\_\_\_\_

12. Has your child had any recurring knee, foot, or ankle problems, or any injury to his/her muscles, joints or bones during the past year? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, please explain. \_\_\_\_\_

\_\_\_\_\_

13. Please notify us if your child has any other problems we should be aware of, such as phobias, car sickness, bedwetting, bronchitis, sleepwalking, nightmares, etc.

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**SPECIAL ACTIVITIES PERMISSION FORM**

1. I { \_\_\_\_\_grant/ \_\_\_\_\_ do not grant} permission for my son/daughter to go swimming during the program. I understand that he/she will be supervised. He/she is a:

- \_\_\_\_\_ a non swimmer
- \_\_\_\_\_ a beginning swimmer
- \_\_\_\_\_ an intermediate swimmer
- \_\_\_\_\_ a strong swimmer

2. I { \_\_\_\_\_grant/ \_\_\_\_\_ do not grant} permission for my son/daughter to participate in supervised program bicycle trips. I understand that he/she will be required to wear a helmet and follow program bike safety rules.

3. I { \_\_\_\_\_grant/ \_\_\_\_\_ do not grant} permission for my son/daughter to go in a boat, or canoe, under supervision, to collect data samples.