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Recommended Vaccination Acknowledgment

I, _____, have been informed that the following Vaccinations are recommended by the State and understand I must EITHER provide updated proof of immunity OR refusal for ALL vaccinations that are listed below.

- Hepatitis B
- Tetanus (expires every 10 years)
- Diphtheria
- Pertussis
- Varicella
- Influenza (expires every years)

My signature indicates my refusal for all listed immunizations that I have not submitted proof of immunity for and/or my agreement to keep my record up to date for ALL vaccinations that require it.

Signature

Date