Immunization Record

Please submit a valid immunization record for each enrolling student. This form is not necessary if a print-out from a Doctor's office can be submitted.

Student Information

Student's Last Name _____ First Name _____ Middle Initial _____ ☐ M ☐ F Gender

Date of Birth _____ Grade _____

Known Allergies _____

Immunizations

Instructions to healthcare provider: Indicate the dates you or another provider gave the patient the Vaccine Information Statement (VIS) and administered the dose.

Vaccine		Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTaP/DTP/DT/Td	Diphtheria, Tetanus, and Pertussis						
Tdap Booster	Tetanus, Diphtheria and Pertussis						
OPV/IPV	Polio						
HepB	Hepatitis B						
HepA	Hepatitis						
MMR	Measles, Mumps, Rubella						
Varicella	Chickenpox						
PCV	Pneumococcal Conjugate Vaccine						
Td Booster	Tetanus Booster						
Hib	Haemophilus Influenza Type b						
HPV	Human Papillomavirus						
ROTA	Rotavirus						
TST	Tuberculin Skin Test						
MCV	Meningococcal Vaccine						
Influenza	Influenza						