Student Name:_____ D.O.B.: _____

ALL CHILDHOOD IMMUNIZATION DATES MUST BE RECORDED ON THIS FORM (ATTACHMENTS NOT ACCEPTED)

REQUIRED IMMUNIZATIONS

MMR (2 injection dates required)

Date #1 ____/____/_____ (Given after 12 mos of age)

Date #2 ____/____/_____ (Given at 4-6 yrs or later)

OR

Titer Date: ____/____/_____ Results: _____

POLIO

Date Primary Series Completed: ____/____/_____

DPT

Date Primary Series Completed: ____/____/_____

TD/Tdap Booster)

Date: ____/____/_____ **(DATE MUST BE WITHIN LAST 10 YEARS)**

VARICELLA

History of Disease Yes _____ **OR** Date of positive titer: ____/____/_____

OR TWO DOSES REQUIRED

Immunization dose #1 date: ____/____/_____
Immunization dose #2 date: ____/____/_____

MENINGOCOCCAL

Vaccine date: ____/____/_____

Booster date: _____/_____/_____ (Recommended)

You Must Sign Waiver on Page 4

RECOMMENDED IMMUNIZATIONS

HEPATITIS B

Dose #1 date: ____/____/_____
Dose #2 date: ____/____/_____
Dose #3 date: ____/____/_____

GARDASIL

Dose #1 date: ____/____/_____
Dose #2 date: ____/____/_____
Dose #3 date: ____/____/_____