Immunization Record

DATE _____ 20_____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD	DATE OF BIRTH	SEX
_____ Last First Middle		☐ ☐ M F

ADDRESS

_____
No. and Street City or Post Office Borough or Township County State Zip Code

IMMUNIZATIONS AND TESTS

VACCINE	Enter Month, Day, and Year each immunization was given **DOSES**			**BOOSTERS & DATES**	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date: _____		
Other: _____					

☐ MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health
☐ RELIGIOUS EXEMPTION (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

Tuberculin Tests Date Applied	**Arm**	**Device**	**Antigen**	**Manufacturer**	**Signature**
Date Read	**Results (mm)**		**Signature**		

Follow-Up of significant tuberculin tests:
Parent/Guardian notified of significant findings on _____.

Result of Diagnostic Studies: _____.
Preventive Anti-Tuberculosis – Chemotherapy ordered. ☐ No ☐ Yes _____ Date