SCHOOL IMMUNIZATION RECORD

Student name: _____

Sex: M ____ F ___

Date of birth: _____

Phone number: _____

Address: _____

City: _____

Name of parent/guardian: _____

Please complete the Immunizations below OR upload the printed list of immunizations from the doctor's office:

Vaccine (number of doses required)	Date each dose was given (Must include month, date & year)					
	1st	2nd	3rd	4th	5th	Booster
Polio (OPV or IPV) (4 doses)						
DTaP/DTP/DT/Td (4 doses) (1 dose Tdap)						
MMR (Measles, mumps & Rubella) (2 doses)						
Hepatitis B (3 doses)						
Varicella (Chickenpox) (2 doses)						