THIS FORM MUST BE SIGNED BY A HEALTH CARE PROVIDER

Immunization Record

This form must be completed and submitted before your child's registration is complete.
This form must be updated annually by a health care provider.

Child's full name _____ Birthdate_____/_____/_____

Parent/Guardian name_____ Phone _____

Hep A					
Hep B					
DtaP/DTP/Td					
Hib					
MMR					
IPV					
Varicella					
PCV/Prevanar					

Date of last Tetanus shot: _____

Child has documented history of Chicken Pox? _____No _____Yes If yes, age _____

Parent Comments: (Please indicate religious objections, if any.) _____

_____

Health Care Provider Comments: (Please list immunizations excluded for medical purposes.)

_____

_____

Please check the appropriate response:

___ Child has received age-appropriate immunizations.

___ Child is currently in the process of receiving age-appropriate immunizations.

Signed _____ Date_____
Health Care Provider's Signature (Required)

Printed Name and Title _____