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.) ____________________________

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

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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 ____