Immunization Health History Record

Student Name: _____ **Student ID number:** _____

Date of Birth: _____ **Phone:** _____

SECTION A: REQUIRED VACCINES

	Month/Day/Year	Month/Day/Year	Month/Day/Year
MMR / MEASLES, MUMPS, RUBELLA VACCINE			DO NOT WRITE HERE
MCV4 (MENACTRA/MENVEO) / MENINGOCOCCAL MENINGITIS VACCINE			DO NOT WRITE HERE
TDAP (TETANUS/DIPHTHERIA/PERTUSSIS)			DO NOT WRITE HERE
VARICELLA (CHICKENPOX)			DO NOT WRITE HERE
POLIO			

Section B: Recommended (but not mandatory) for Good Health

	Month/Day/Year	Month/Day/Year	Month/Day/Year
HEPATITIS B VACCINE			
NEGATIVE PPD (TUBERCULOSIS SKIN TEST) OR NEGATIVE CHEST X-RAY WITHIN 1 YEAR			

_____ _____

Signature of Student Date

_____ _____ _____

Signature of Parent or Guardian if student under the age of 18 Relationship to Student Date

An official stamp from a doctor's office, clinic or health department AND an authorized signature must appear here or this form will not be approved.

_____ _____ _____

Official Office Stamp Here **Physician Or Authorized Signature** **Date**