A printed copy of doctor's records may be attached to this sheet. Please have doctor sign front of page.

Print Child's Name _____ VACCINE	**Enter Month, Day And Year Each Immunization Was Given DOSES School year 2024-2025**			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					

		*****Physician, please sign below acknowledging that the immunization information listed above is correct.**			
		Signature			

Immunization and Test History

(To be completed by physician)