

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

<u>Print Child's Name</u> _____	Enter Month, Day And Year Each Immunization Was Given DOSES School year 2023-2024			BOOSTERS & DATES	
VACCINE					
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.		
			<u>Signature</u>		

Immunization and Test History
(To be completed by physician)