HEALTH SERVICES DEPARTMENT

Immunization History

TO BE COMPLETED BY PARENT ___________________________

Student's name *(last, first)* ______________________ Birth date ___/___/___

SEX: ☐ M ☐ F Street address ______________________ School ______________ Grade____

Parent/Guardian name ______________________ Home phone ______________

CHICKENPOX DISEASE:

☐ Yes, my child has had chickenpox. Date of chickenpox _________

☐ No, my child has not had chickenpox.

IMMUNIZATIONS ARE REQUIRED ATTIME OF ENROLLMENT Completed immunizations are required by Indiana State *Law for all school children. Please have your family physician record your child's immunization history below or return a copy of the most current immunization record to your child's school. Note that the law provides for exclusion from school for failure to comply with the immunization requirement, unless a parent submits a written statement of objection.*

TO BE COMPLETED BY PHYSICIAN/CLINIC ___________________________

DATE(S) OF IMMUNIZATION/TEST

DTP/DTaP					
Td					
OPV					
IPV					

MMR #1		*or*	Measles	
MMR #2			Mumps	
			Rubella	

Hepatitis A				
Hepatitis B				
Varicella			☐ Has had chickenpox. Date ________	
Teen Tdap				
Teen Meningococcal MCV				
Other		Type ________		
Most recent TB		Type ________	Result ________	

Health care provider's signature ______________________ Date ______________

Revised 3/2014