## IMMUNIZATION REPORT

Please Print Student's Name		Birth Date	Sex	Responsible Party				ID#
Address	T-11-11-11-11-11-11-11-11-11-11-11-11-11	Parent/Guardian			Telephone			
					Home Work			
mmunizations to be completed by health was given after the minimum interval or the contraindication.	n care provider. Nage. If a specific	Note the mo/day/yr f	or every dose admi y contraindicated, a	inistered. Tl a separate w	he day and vritten stat	d month is required in the month is required in the month in the attack.	f you cannot determ hed explaining the	nine. If the vaccii
VACCINE/DOSE		1 MO/ DAY/ YR	2 MO/ DAY/ YR	MO/ DA		4 MO/ DAY/ YR	5 MO/ DAY/ YR	MO/ DAY/ Y
Boostrix T-dap								
Adacel								
Pediarix (DTaP, IPV, Hep	B)			<u> </u>				
Pentacel (DTaP, IPV, HII	3)							
Diptheria, Tetanus & Pertussis (DT	P or DTaP)						***	
Pediatric DT or Td (Decays	ac)							
Inactivated Polio (IPV)								
Oral Polio (OPV)								
Kinirix (DTAP, IPV)				,				
Haemophilus Influenzae type b	(Hib)							
DTAP/Hib								
Hepatitus B (HB)								
Convax (Hib & Hep B)			······					
Varicella (Chickenpox)								
Combined Measles, Mumps, & Rube	ella (MMR)							
Measles (Rubeola)								
Rubella (3-Day measles)								
Mumps								
Proquad (MMR & Varicell	a)						•	
Pneumococcal			* *					
Hepatitis A								
Meningococcal			**************************************					
PPD								
Flu Vaccine	Ó							
271							***************************************	
Typhoid								
BCG								
Rotarix			www.i					
Rotateq		:						
Gardisil								
omments: Lead blood: itres: Varicella	HCT Measles	HGB Mump		oella				
lealth Care Provider (MD/RN School he	alth professional	health official) veri	fying the above im	munization	history m	nst sign here		
	1		_,e accore iiii		moonly III	iust sign nere		