# Immunization History Form

The following is **REQUIRED** for all students

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date 1: Month/Day/Yr</th>
<th>Date 2: Month/Day/Yr</th>
<th>Date 3: Month/Day/Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>TDAP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td>Disease Date:________</td>
</tr>
<tr>
<td>Meningoccal</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other Immunizations**

Not required for entry, recommended unless specified

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date 1: Month/Day/Yr</th>
<th>Date 2: Month/Day/Yr</th>
<th>Date 3: Month/Day/Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polio</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPD</td>
<td></td>
<td>Negative ( ) Positive ( ) REQUIRED for students living in high risk area</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Papilloma Virus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typhoid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yellow Fever</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Provider’s Signature_________________________ Date________________

Address___________________________________________________________________________________

Telephone_________________________________________________________________________________