

CHILD'S NAME \_\_\_\_\_ LAST FIRST MI

SEX: MALE • FEMALE • BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_

COUNTY \_\_\_\_\_ SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

PARENT OR GUARDIAN NAME \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

**RECORD OF IMMUNIZATION : See Notes**

VACCINE TYPE						VACCINE TYPE				
DOSE #	DTP-DT aP MO/DAY/YR	DT-Td MO/DAY/YR	Polio MO/DAY/YR	Hib MO/DAY/YR	Hep B MO/DAY/YR	DOSE #	M-M-R MO/DAY/YR	MEASLES MO/DAY/YR	RUBELLA MO/DAY/YR	MUMPS MO/DAY/YR
1						1				
2						2				
3						DOSE #	Varicella MO/DAY/YR	OTHER VAX MO/DAY/YR	OTHER VAX MO/DAY/YR	OTHER VAX MO/DAY/YR
4						1				
5						2				

To the best of my knowledge, the vaccines listed above were administered as indicated.

1. \_\_\_\_\_  
 Signature Title Date
2. \_\_\_\_\_  
 Signature or Initial Title Date
3. \_\_\_\_\_  
 Signature or Initial Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

**LOST OR DESTROYED RECORDS: (Must Be Reviewed and Approved by Local Health Department. See Notes)**

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
 Parent or Guardian

**COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.**

**MEDICAL CONTRAINDICATION:**

The physical condition of the above pupil is such that immunization at this time would constitute a serious threat to his/her health.  
 This is a permanent condition • temporary condition • until \_\_\_\_/\_\_\_\_/\_\_\_\_

Check appropriate box, indicate vaccine(s) and reasons: \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_  
 Physician or Health Official

**RELIGIOUS OBJECTION:**

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunization being given to my child.

Signed \_\_\_\_\_ Date \_\_\_\_\_