

# IMMUNIZATION RECORD

Student Name \_\_\_\_\_ DOB \_\_\_\_\_

DPT or DT or TD \_\_\_\_\_  
Date Date Date Date Date

Polio \_\_\_\_\_  
Date Date Date Date Date

Measles \_\_\_\_\_  
Date Date Date

Mumps \_\_\_\_\_  
Date Date Date

Rubella \_\_\_\_\_  
Date Date Date


Hepatitis B \_\_\_\_\_  
Date Date Date

Meningococcal \_\_\_\_\_  
Date Date Date

Varicella \_\_\_\_\_  
Date Date

Other \_\_\_\_\_  
Date Date Date

Other \_\_\_\_\_  
Date Date Date

Physician's/Provider's Stamp: 

Physician's / Provider's Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_