



Name: _____ Date of Birth: _____
(First) (Middle) (Last) (MM/DD/YY)

1. **DIPHTHERIA AND TETANUS TOXOIDS** All students should have had a basic series of 3 doses of DIPHTHERIA AND TETANUS TOXOIDS. These are usually given with Pertussis (in DTP) in infancy. A booster dose of DIPHTHERIA AND TETANUS TOXOIDS, Adult Type (Td) is needed every 10 years to maintain immunity. If the last dose of the toxoid was received more than 10 years ago, a single booster dose of Td is required.

BASIC SERIES with DTaP or DTP:

#1 ____/____ #2 ____/____ #3 ____/____ #4 ____/____
MM YY MM YY MM YY MM YY

TETANUS-DIPHTHERIA (Td) BOOSTER (within the last ten years): ____/____
MM YY

2. **MMR (MEASLES-MUMPS-RUBELLA)**

Two doses are required.

1. Dose 1 given at age 12-15 months or later #1 ____/____
MM YY

2. Dose 2 given at age 4-6 years or later, and at least one month after first dose #2 ____/____
MM YY

3. **POLIO**

Primary series in childhood meets requirement; three primary series schedules are acceptable.

OPV alone (oral Sabin three doses): #1 ____/____ #2 ____/____ #3 ____/____
MM YY MM YY MM YY

Or IPV/OPV sequential: IPV #1 ____/____ IPV #2 ____/____ OPV #1 ____/____ OPV #2 ____/____
MM YY MM YY MM YY MM YY

Or IPV alone (injected Salk four doses): #1 ____/____ #2 ____/____ #3 ____/____ #4 ____/____
MM YY MM YY MM YY MM YY

4. **HEPATITIS B**

Three doses of vaccine or a positive Hepatitis B surface antibody meet the requirements.

Immunization (Hepatitis B) #1 ____/____ #2 ____/____ #3 ____/____
MM YY MM YY MM YY

Or Immunization (Hepatitis A and B vaccine) #1 ____/____ #2 ____/____ #3 ____/____
MM YY MM YY MM YY

Or Hepatitis B surface antibody ____/____ Result: Reactive Non-reactive
MM YY

5. **VARICELLA**

A history of chicken pox, or a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized at the age of 13 or older meet the requirement.

1. History of Disease: YES NO

2. Varicella Antibody: ____/____ Result: Reactive Non-reactive
MM YY

3. Immunization: #1 ____/____ #2 ____/____
MM YY MM YY

6. **TUBERCULIN SKIN TEST OR CHEST X-RAY (Test must not be older than 6 months.)**

Date Given: ____/____/____ Date Read: ____/____/____
MM DD YY MM DD YY

Result (record actual mm induration, transverse diameter; if no induration, write "0"): _____

Interpretation (based on mm of induration as well as risk factors): POSITIVE NEGATIVE

Chest X-ray result (required if tuberculin skin test is positive): NORMAL ABNORMAL Date of Chest X-ray: ____/____/____
MM DD YY

HEALTH CARE PROVIDER

NAME: _____ Address: _____

Signature: _____ Date: _____ Phone: _____

