Immunization Records

Date: _____

Student's Name:_____

Date of Birth:_____

Student's Physician: _____

Physician's Address: _____

Physician's Phone: _____

My child has been immunized for the following on the following dates.
(Check and give dates)

DPT _____ Polio_____

Measles _____ Mumps_____

Rubella _____ HIB _____

OR

I refuse to have my child immunized _____

_____
Signature of Parent/Guardian

A copy of the student's immunization record from the physician or health unit attached to this form is acceptable and preferred.