Student Name _____ **Sex:** M ☐ F ☐ **Birthdate** _____ **Place of Birth** _____

Name of Parent or Guardian _____ **Race/Ethnicity:**

☐ White, not Hispanic
☐ Hispanic
☐ Black
☐ Other: _____

Address _____

Telephone _____ (Daytime) _____ (Nighttime) **City** _____ **ZIP** _____

VACCINE	DATE EACH DOSE WAS GIVEN					
	1st	2nd	3rd	4th	5th	Booster
POLIO (OPV or IPV)						
DTP/DTaP/DT/Td (Diphtheria, tetanus and [acellular] pertussis OR tetanus and diphtheria only)						
MMR (Measles, mumps, and rubella)						
HIB (Required only for child care and preschool)						
HEPATITIS B						
VARICELLA (Chickenpox)						
HEPATITIS A (Not required)						

TB SKIN TESTS	Type*	Date given	Date read	mm indur	Impression
	☐ PPD-Mantoux ☐ Other				☐ Pos ☐ Neg
	☐ PPD-Mantoux ☐ Other				☐ Pos ☐ Neg

*If required for school entry, must be Mantoux unless exception granted by local health department.

CHEST X-RAY (Necessary if skin test positive)

Film date: _____ Impression: ☐ normal ☐ abnormal

Person is free of communicable tuberculosis: ☐ yes ☐ no

Immunization history

This part is for [Office use only]

Siganture