

IMMUNIZATION RECORDS

Student's Name _____ Date of Birth _____

<u>Immunizations</u>	<u>Dates (month/day/year)</u>	<u>Minimum Required</u>
DTP or td (Diphtheria, Tetanus Pertussis)	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___	Infant series of 5 boosters before 4 th birthday. Td booster every 10 years thereafter.
Oral Polio Vaccine	___/___/___ ___/___/___ ___/___/___ ___/___/___	Infant series of 4 boosters
MMR (Measles, Mumps, Rubella)	___/___/___ ___/___/___	2 doses before 7 th grade

Parent/Guardian Signature

This form may be completed or you may submit a copy of the participant's immunization record.