IMMUNIZATION RECORD

PART 1 – TO BE COMPLETED BY THE STUDENT

Name: _____
Last First Middle I.
Date of Birth: _____SS# _____Phone_____
Month/Day/Year
Address: _____
Street P O Box City ST Zip Code
Date of Enrollment at OLC: _____

PART 2 – TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER
Dates must include month and year-Required by all students

Hepatitis B Vaccine:
Date Began: _____ Date of 2nd injection: _____Date complete: _____

The student should have received the first two of the series by the time classes start.

Tuberculosis-Check appropriate box
1. _____PPD test within the past year (Tine or Mantoux not acceptable)
Give Date and test results: _____
Month Year
2. _____Positive PPD-Chest x-ray required. Give date & result of chest x-ray:
_____
Month Year
3. _____Had BCG vaccine-Chest x-ray required if PPD not done, with results:
_____
Month Year

MMR-Check appropriate box (Measles, Mumps and Rubella)

1. _____Has report of immune titer. Specify date of titer_____
Month Year

2. _____Immunized with vaccine at 12 months of age (or later) _____
and Month Year

3. _____second Immunization (usually at 4-6 years) _____
Month Year

1. _____Had disease; confirmed by office record_____
Month Year

Tetanus-Diphtheria

1. Completed primary series of tetanus-diphtheria immunization_____/____/____
Month/ Year

2. Received tetanus-diphtheria booster within last ten years_____
Month Year

Polio

1. _____Completed primary series of polio immunizations. Yes_____ No_____
Type of vaccine: _____oral_____inactivated_____E-IPV

Health Care Provider

Name_____

Address_____

Signature_____

Phone_____

Revised 6-2008