Child's Name_____

History of Immunizations and Tests (indicate month/day/year)

DTaP/DTP/DT/Td	_____	_____	_____	_____	_____ **Tetramune? Yes/No**
Polio	_____	_____	_____	_____	
MMR	_____	_____			
Hib	_____	_____	_____	_____	**Comvax? Yes/No**
Hep. B	_____	_____	_____		
PCV	_____	_____	_____	_____	
Varicella	_____				

NOTE:

Minimum immunization requirements for enrollment (3 years – 5 years) 4DTaP/DTP/DT/Td; 3 Polio; 1 MMR; 4 Hib; 3 Hep.B; 4 PCV (1 dose minimum); 1 Varicella (MMR-one dose must be given on or after date of first birthday)

Physician Completing Form:_____**Phone No.**_____

(Please Print)

Physician's Signature:_____**Date:**_____

Additional Notes and Instructions

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