IMMUNIZATION RECORD FORM

To be completed by parent for every student upon enrollment. Please include the month, day, and year for each immunization.
Forms can be faxed: ATTN School Nurse, 330-653-1234 (for Kindergarten) or 330-653-1235 (for Preschool)

In lieu of completing this form, a copy of the child's immunization record may be submitted.

STUDENT NAME:	**SEX:** ☐ Male ☐ Female	**BIRTHDATE:** / /

VACCINE	**RECORD COMPLETE DATES (MONTH-DAY-YEAR) OF VACCINE DOSES GIVEN**					
Diphtheria, Tetanus, Pertussis (DTP)						
DTaP, Tdap						
DT, Td						
Polio						
Hepatitis B (HBV)						
Measles, Mumps, Rubella, (MMR)						
Varicella (Chickenpox)						
Measles (Rubeola) only						
Rubella only						
Mumps only						
Haemophilus influenza Type b (Hib)						
Other						

THIS INFORMATION WAS PROVIDED BY: ☐ HEALTH CARE PROVIDER ☐ PARENT/GUARDIAN

☐ OTHER: _____

SIGNATURE:		**DATE:** / /
PRINTED NAME:		

Students are required to be immunized in accordance with Ohio law (ORC 3313.67/3313.671).

5/20/09
3/16/15