Cambrian Academy

IMMUNIZATION HISTORY/RECORD

Student Name:_____ Date of Birth:_____/_____/_____

Vaccines: Give **date (mo/day/year)** each dose was given.	1st	2nd	3rd	4th	5th
Polio (TOPV)					
DPT and/or DT (Diptheria, Tetanus)					
DPT and/or DT (Diptheria)					
Measles (Rubeola-10 day, red measles)					
Rubella (German Measles, 3-day measles)					
Mumps					
Varicella (Chicken Pox)					
Hepatitis B					

IMMUNIZATIONS REQUIRED FOR ADMISSION INTO AMERICAN HIGH SCHOOLS		
1. Polio	At least 3 doses	Additional doses required if last dose was received before 4 years of age.
2. Diptheria-Tetanus-Pertussis (DPT) and/or Diptheria-Tetanus OR (TD) only (if 7 years and over).	At least 4 doses or At least 3 doses	Booster required within past 10 years.
3. Measles (Rubeola-10 day, red measles)	Two doses on or after one year of age OR laboratory-confirmed disease verified by a physician plus one dose.	
4. Rubella (German Measles, 3-day measles)	Two doses on or after one year of age OR laboratory-confirmed disease verified by a physician plus one dose.	
5. Mumps vaccine	Two doses on or after one year of age OR laboratory-confirmed disease verified by a physician plus one dose.	
6. Varicella (Chicken Pox)	One dose on or after one year of age , but prior to age 13 OR two doses administered at least 28 days apart after age 13 OR laboratory-confirmed disease verified by a physician.	
7. Hepatitis B	Three doses recommended.	

Tuberculosis (TB) Skin Test Date _____ (needs to be within past six months) ___ Positive ___ Negative/Normal
Please explain any positive reaction and follow-up: _____

I, the undersigned, have given a thorough physical examination and reviewed the medical history of this student. I certify that all important medical information has been included, and that the above information is complete and accurate.

Physician's Signature: _____ Date: _____

Physician's Name Printed: _____

Medical License Number or Seal: _____

Physician's Business Address: _____