ATTACHMENT F – IMMUNIZATION RECORD

Hillcrest Educational Centers

IMMUNIZATION RECORD

Name: _____ Date of Birth: / / Sex: M F

If Combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HebB-Hib, DTaP-HepB-IPV, HepA-HepB	1		Rotavirus (e.g., RV5: 3 dose series RV1: 2 dose series)	1	
	2			2	
	3			3	
	4		Measles, Mumps, Rubella (MMR, MMRV)	1	
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, Td, Tdap)	1			2	
	2		Varicella (Var, MMRV)	1	
	3			2	
	4		Meningococcal (Conjugate (MCV4) or Polysaccharide (MPSV4)	1	
	5			2	
	6		Influenza Inactivated (Intramuscular) or Live (Intranasal)	1	
	7			2	
Haemophilus Influenzae Type b (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib)	1			3	
	2			4	
	3			5	
	4			6	
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib)	1		Pneumococcal Polysaccharide (PPV23)	1	
	2			2	
	3		Hepatitis A (HepA, HepA-HepB)	1	
	4			2	
	5		Human Papillomavirus (HPV)	1	
Pneumococcal Conjugate (PCV7)	1			2	
	2			3	
	3		Other:		
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
*Must also check Chickenpox History Box			

Chickenpox History
Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: • physician interpretation of parent/guardian description of Chickenpox • physical diagnosis of chickenpox, or • serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or Nurse's name (please print): _____ Date: / /

Signature: _____

Facility name: _____

Hillcrest Educational Centers VER 1 (4/2009)