ANNUAL IMMUNIZATION FORM

TO BE COMPLETED BY A DOCTOR OR NURSE PRACTITIONER

First Name:	Last Name:	Date of Birth:

Directions for Physician or Clinic: * Enter all appropriate doses and dates below * Sign and date appropriate Certificate section

VACCINE	Dose 1 MM/DD/YY	Dose 2 MM/DD/YY	Dose 3 MM/DD/YY	Dose 4 MM/DD/YY	Dose 5 MM/DD/YY
DTaP/DTP/DT/Tdap/Td					
Polio					
Hib					
MMR (Combined)					
Hepatitis B					
Varicella					
Pneumococcal Conj (PCV)					
Meningococcal (MCV4)					
Hepatitis A					

Check appropriate line for Certificate of Immunization for PK-12

_____ Immunizations are Complete PK-12 (excluding 7th grade/middle school requirements).

_____Immunizations are Complete for 7th grade

I have reviewed the records available, and to the best of my knowledge, the above-named child has adequately been immunized for school attendance, as documented above.

Temporary Medical Exemption **Expiration Date:** _____

_____ I certify that the above-named child has received the immunizations documented above and has commenced a schedule to complete the required immunization. Additional immunizations are not medically indicated at this time.

Permanent Medical Exemption:

_____I certify that the physical condition of this child is such that the immunizations listed above are medically exempt

Physician or Clinic Name:	Physician or Authorized Signature:
	Date: