

IMMUNIZATION RECORD.

(REQUIRED IN ADDITION TO HEALTH HISTORY FORM)

Student's Name:

Last First Mi

Student ID 9-Digit Number: _____ - _____ - _____

Date of Birth _____ / _____ / _____

Please complete and sign either Section I or all three parts of Section II or Section III.

SECTION I

List TWO dates of "MMR" (Measles, Mumps, Rubella) vaccine inoculation:

_____ & _____

Physician's signature
OR Attach copy of Immunization Record.

Date

SECTION II

A. MEASLES -Complete. **ONE** of the following.

1. TWO dates of Measles vaccination: _____ & _____

2. Approximate date of Measles infection (disease): _____

3. Date of blood test for Measles Immunity: _____

B. MUMPS -Complete ONE of the following.

1. Date of Mumps vaccination: _____

2. Approximate date of Mumps Infection (disease): _____

3. Date of blood test for Mumps immunity: _____

C. RUBELLA (German Measles) -ONE of the following **MUST** be completed: vaccination or blood test required.

1. Date of Rubella vaccination: _____

2. Date of blood test for Rubella Immunity: _____

Physician's signature

Date

Section III

Proof of birth date prior to January 1, 1957. Please attach a copy of one of the following: driver's license, birth certificate, baptismal certificate, or passport.