Student name: Last_____, First_____ Student ID:_____

Immunization Requirement

- SFS follows the U.S. CDC immunization schedule. Please help us ensure the student's vaccinations are up to date and he/she has received booster vaccinations of DTaP, Polio & MMR at age 4-6 and Tdap at age 11-12.
- **Please PRINT the exact dates (mm/dd/yr) of vaccinations received.**

Immunization Records

Type of Vaccine	1st Dose mm/dd/yr	2nd Dose mm/dd/yr	3rd Dose mm/dd/yr	4th Dose mm/dd/yr	5th Dose mm/dd/yr
DPT/DTaP: Diphtheria, Tetanus, & Pertussis	2 months	4 months	6 months	15-18 months	4-6 years
	/ /	/ /	/ /	/ /	/ /
Tdap: Tetanus, Diphtheria, & Pertussis	11-12 years				
	/ /				
Polio	2 months	4 months	6-18 months	4-6 years	
	/ /	/ /	/ /	/ /	
MMR: Measles, Mumps, & Rubella	12-15 months	4-6 years			
	/ /	/ /			
Hepatitis B	#1	#2	#3		
	/ /	/ /	/ /		
Varicella: Chicken pox OR Disease History	12-15 months	4-6 years	**Disease History**		
	/ /	/ /	/ /		

Physician Signature	**Date of Examination (mm/dd/yr)**
Physician's Printed Name	**Clinic Name & Phone Number**