**Student Information:**

1. **Student Name:**
   * Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Grade/Class: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Parent/Guardian Information:**
   * a. **Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
     + Relationship to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
     + Phone (Primary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
     + Phone (Alternate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * b. **Emergency Contact (Other): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
     + Relationship to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
     + Phone (Primary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
     + Phone (Alternate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccination History:**

1. **Vaccine Type:**
   * Diphtheria, Tetanus, Pertussis (DTaP/Tdap)
   * Polio (IPV)
   * Measles, Mumps, Rubella (MMR)
   * Hepatitis B
   * Varicella (Chickenpox)
   * Haemophilus influenzae type b (Hib)
   * Pneumococcal Conjugate (PCV)
   * Meningococcal
   * Human Papillomavirus (HPV)
   * Influenza (Flu)
   * Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Date of Vaccination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Dose Number (e.g., 1st, 2nd, Booster): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **Vaccination Provider (Doctor, Clinic, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. **Lot Number/Batch Number (if available): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vaccination Schedule:**

Use the following table to record each vaccine dose:

| **Vaccine Type** | **Date of Vaccination** | **Dose Number** | **Vaccination Provider** | **Lot/Batch Number** |
| --- | --- | --- | --- | --- |
| Diphtheria, Tetanus, Pertussis |  |  |  |  |
| Polio |  |  |  |  |
| Measles, Mumps, Rubella |  |  |  |  |
| Hepatitis B |  |  |  |  |
| Varicella |  |  |  |  |
| Hib |  |  |  |  |
| PCV |  |  |  |  |
| Meningococcal |  |  |  |  |
| HPV |  |  |  |  |
| Influenza |  |  |  |  |
| Other (Specify) |  |  |  |  |

**Additional Information:**

1. **Allergies or Adverse Reactions to Vaccines:**
   * None
   * Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Medical Exemptions:**
   * None
   * Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Religious or Philosophical Exemptions:**
   * None
   * Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Healthcare Provider's Certification:**

I hereby certify that the above information is accurate and complete to the best of my knowledge.

**Healthcare Provider's Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Healthcare Provider's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**