

Required Immunization Health History Form

Revised February 2014  
Regina USD. Please Print.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last  
First Initial Month Day Year

Social Security Number: XXX - XX- \_\_\_\_\_ Student I.D. # \_\_\_\_\_ Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_@\_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Dose: 1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose: 2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year Month Day Year

Dose: 1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose: 2 \_\_\_\_/\_\_\_\_/\_\_\_\_

Dose: 1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose: 2 \_\_\_\_/\_\_\_\_/\_\_\_\_

Dose: 1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose: 2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year Month Day Year

Measles Titer/Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mumps Titer/Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Rubella Titer/Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Dose: 1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose: 2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year Month Day Year

Declined Vaccination Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Dose: 1 \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Declined Vaccination Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Dose: 2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Dose: 3 \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Result: Neg \_\_\_\_ Pos \_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Chest Xray Result: Normal \_\_\_\_ Abnormal \_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year Month Day Year

History of Disease: \_\_\_\_/\_\_\_\_/\_\_\_\_ or Titer Date \_\_\_\_/\_\_\_\_/\_\_\_\_ OR Varivax Dose: 1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose: 2 \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Name of Clinic or Physician Physician or Authorized Signature Date

Address: \_\_\_\_\_  
Street

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I a F REQUIRED  
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MMR R b S Da a S a La

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S C V  
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D 57069  
(605) 677-3700  
F (605) 677-3701

SANFORD  
Vermillion