

# Required Immunization Health History Form

Revised \_\_\_\_\_  
Regulation in a 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

Measles Titer/Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_

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

Mumps Titer/Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_

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

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 \_\_\_\_/\_\_\_\_/\_\_\_\_

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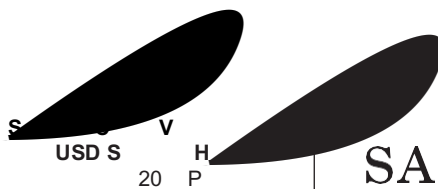
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