Required Immunization Health History Form

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egi a i n a USD. Plea e P in .

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

[illegible]

[illegible]

Dose: 1___/___/___ Dose: 2___/___/___
Month Day Year Month Day Year

[illegible]

Dose: 1___/___/___ Dose: 2___/___/___

[illegible]

Dose: 1___/___/___ Dose: 2___/___/___

[illegible]

Dose: 1___/___/___ Dose: 2___/___/___
Month Day Year Month Day Year

[illegible]

Measles Titer/Date / /

MumpsTiter/Date ___ /_____ /

Rubella Titer/Date / ___ /
Month Day Year

[illegible]

[illegible]

Dose: 1___/___/___ Dose: 2___/___/___ Declined Vaccination Date:___/___/___
Month Day Year Month Day Year Month Day Year

[illegible]

Dose: 1___/___/___ Declined Vaccination Date:___/___/___
Month Day Year Month Day Year

Dose: 2___/___/___
Month Day Year

Dose: 3___/___/___
Month Day Year

[illegible]

[illegible]

Result: Neg_☐_Pos_☐_Date:___/___/___Chest Xray Result: Normal_☐_Abnormal_☐_Date:___/___/___
Month Day Year Month Day Year

[illegible]

History of Disease:___/___/___or Titer Date___/___/___OR Varivax Dose: 1___/___/___Dose: 2___/___/___

☐☐

[illegible]

_____ _____ _____
Name of Clinic or Physician Physician or Authorized Signature Date

Address: _____
Street

S C V
USD S H
20 P
, D 57069
(605) 677-3700
F (605) 677-3701

SANFORD
Vermillion