Health Assessment Record
Immunization History

Name of Child_____ D.O.B._____

School_____

The above named child has received the following immunizations:

Vaccine	Date Administered
Tdap	_____
MCV	_____

I certify that the above named child has had the immunizations indicated above.

_____ _____

Signature of Health Care Provider **Date**

_____ _____

Name of Health Care Provider (Please type or print) **Phone Number**

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Form C Rev. 3-11, 5-14, 6-18