ANDOVER PUBLIC SCHOOLS
USD 385

DEPARTMENT OF HEALTH SERVICES
Immunization Received

Student's Printed Name: _____ Date of Birth:_____

School Attendance Center:_____ Grade:_____

Vaccine	Date Administered
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This is to certify that the above named child has received the vaccine(s) indicated.

Physician Name (please print): _____

Signature of Physician:_____ Date:_____

Office Phone number: _____ Fax number: _____