HEALTH and WELLNESS SERVICES
1200 South Barr Street · Fort Wayne, IN 46802 · 260.467.1080

Notice for Immunization for All Student Enrollment

TO BE COMPLETED BY PARENT ______________________________

Student's name (*last, first*) ______________________________ Birth Date ____/____/____

SEX: ☐ M ☐ F Street Address ______________________________ School__________________ Grade ____

Parent/Guardian Name ______________________________ Home Phone ____________________

CHICKENPOX DISEASE:
☐ YES, my child has had chickenpox. Date of Chickenpox ________________________
☐ NO, my child has not had chickenpox

IMMUNIZATIONS ARE REQUIRED AT TIME OF ENROLLMENT Completed immunizations are required by Indiana State Law for all school children. Please have your family physician record your child's immunization history below or return a copy of the most current immunization record to your child's school. Note that the law provides for exclusion from school for failure to comply with the immunization requirement, unless a parent submits a written statement of objection.

TO BE COMPLETED BY PHYSICIAN/CLINIC ______________________________

DATE(S) OF IMMUNIZATION/TEST

DTP/DTap					
Td					
OPV					
IPV					
MMR #1			Measles		
MMR #2		*Or*	Mumps		
			Rubella		
Hepatitis A					
Hepatitis B					
Varicella			☐Has had chickenpox	Date ________________	
Teen Meningococcal MCV					
Other		Type ________________			
Most recent TB		Type ________________		Result: ____________	

Health care provider's signature ______________________________ Date ______________________