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

Immunization History

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		*Or*	Measles		
MMR #2			Mumps		
			Rubella		
Hepatitis A					
Hepatitis B					
Varicella			☐ Has had chickenpox	Date __________	
MCV4					
Men B					
Other			Type __________		
Most recent TB		Result __________			

Health care provider's signature ______________________ Date __________