



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	<i>Or</i>	Measles		
MMR #2		Mumps		
		Rubella		
Hepatitis A				
Hepatitis B				
Varicella			<input type="checkbox"/> Has had chickenpox	Date _____
Teen Meningococcal				
MCV 4				
Other		Type _____		
Most recent TB		Type _____		Result: _____

Health care provider's signature _____ Date _____