



# VIRGIN ISLANDS IMMUNIZATION REGISTRY SYSTEMS (VIIRS) STUDENT'S IMMUNIZATION DATA FORM

Name of Facility: \_\_\_\_\_

Reporting Period: \_\_\_\_\_ Grade: \_\_\_\_\_

**INSTRUCTIONS:** Please **PRINT CLEARLY**, fill out **ALL** the **REQUIRED DATA** and attach a **COPY** of the student's immunization card.  
*(If single birth use "1", if multiple birth (twin, triplet, etc.) use "1" for first born, "2" for second born, etc.*

Birth Status: \_\_\_\_\_ of \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child's First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Child's Last Name: \_\_\_\_\_

Gender:  Male  Female

Home Telephone Number: \_\_\_\_\_ Cell Telephone Number: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Race:  White  Black or African American  Asian American  American Indian/Alaska Native  
 Native Hawaiian/Pacific Islander  Other (please specify): \_\_\_\_\_

Ethnicity:  Hispanic  Non-Hispanic

Mother's First Name: \_\_\_\_\_ Mother's Maiden Last Name: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_ Cell phone Number: \_\_\_\_\_

Father's First Name: \_\_\_\_\_ Father's Last Name: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_ Cell phone Number: \_\_\_\_\_

I agree and understand that my child's immunization information will be entered in the Virgin Islands Immunization Registry System (VIIRS) and may be shared with schools, day-care's, healthcare providers, and any other health care professionals as necessary to verify immunization status and public health studies. It also helps parents/guardians to obtain a duplicate copy of the child's immunization card (if lost).

\_\_\_\_\_  
Date Parent/Guardian (Please Print) Parent/Guardian Signature Relationship