

## STAFF IMMUNIZATION RECORD CARD

<b>STAFF IMMUNIZATION RECORD CARD</b>					
<b>Last Name</b>		<b>First</b>		<b>MI</b>	
<b>Address</b>			<b>Phone</b>		
<b>Date of Birth:</b>	<b>Mo./Day/Yr. Each Dose Was Received</b>				
<b>Type of Vaccine</b>	1 <sup>st</sup> Mo./Day/Yr.	2 <sup>nd</sup> Mo./Day/Yr.	3 <sup>rd</sup> Mo./Day/Yr.	4 <sup>th</sup> Mo./Day/Yr.	5 <sup>th</sup> Mo./Day/Yr.
<b>Tetanus &amp; Diphtheria (Td)</b>	/ /	/ /	/ /	/ /	/ /
<b>Oral Polio Vaccine (OPV)</b>	/ /	/ /	/ /	/ /	/ /
<b>Inactive Polio Vaccine (IPV)</b>	/ /	/ /	/ /	/ /	/ /
<b>Hepatitis B Vaccine (HBV)</b>	/ /	/ /	/ /		
<b>Measles, Mumps, Rubella (MMR)</b>	/ /	/ /			
<b>Measles, Rubella (MR)</b>	/ /	/ /			
<b>Influenza Vaccine</b>	/ /	/ /	/ /	/ /	/ /
<b>Pneumococcal Vaccine</b>	/ /	/ /			
<b>Other</b>	/ /	/ /	/ /	/ /	/ /
History of: _____ year Other _____ Chicken Pox			I request exemption from immunization for: <input type="checkbox"/> Medical Reason <input type="checkbox"/> Religious Beliefs		
In case of injury or sudden illness, _____ will be called. I hereby give authority to any hospital or doctor to render immediately aid as might be required at the time for my health and safety. It is understood by me that the expense of this service will be accepted by me.			Date _____ Signature _____		
			Date _____ Physician Signature for Medical Reasons _____		
<b>If Medical Care is Necessary, Call:</b>					
<b>Doctor: Name</b> _____		<b>Address</b> _____		<b>Phone</b> _____	
<b>Hospital: Name</b> _____		<b>Address</b> _____		<b>Phone</b> _____	