IMMUNIZATION FORM
CHESHIRE ACADEMY

Certification of Immunization

Section I

To be completed and signed by a physician, registered nurse, or health department official.

A copy of the immunization record signed or stamped by a physician, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name: _____ Date of Birth: |___|___|___|
Last *First* *Middle* *Mo. Day Yr.*

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP, TD)-last dose must be given after age 4	1	2	3	4	5
*Tdap booster (after age 11)	1				
*Poliomyelitis (IPV, OPV)- last dose must be given after age 4	1	2	3	4	
*Meningococcal Vaccine (MCV4) or (A,C,Y,X-135) after age 11	1				
*Measles, Mumps, Rubella (MMR vaccine) (doses must be given after age 1	1	2			
Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
Rubella	1		Serological Confirmation of Rubella Immunity:		
Mumps	1	2			
*Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Human Papillomavirus Vaccine	1	2	3		
BCG (International Students)	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

* REQUIRED VACCINES

Signature of Medical Provider or Health Department Official: _____ **Date (*Mo., Day, Yr.*):** ___/___/____