

Immunization record request form texas

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PROVIDENCE
CHRISTIAN COLLEGE

Immunization Record Form

This form should be completed and signed by your doctor or health care provider.

Name _____
(Last Name) (First Name)

Immunization Record*

Hepatitis B Vaccine**
Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____
M Y M Y M Y

MMR (Measles, Mumps, Rubella) Vaccine
Dose #1 ____/____/____ Dose #2 ____/____/____
M Y M Y

Tetanus-Diphtheria Vaccine
Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____
M Y M Y M Y
Td booster (within the last ten years) ____/____/____
M Y

Varicella Vaccine or History of Chickenpox
a. History of Disease ____ Yes ____ No
b. Vaccine (if no history of disease)
Dose #1 ____/____/____ Dose #2 (if applicable) ____/____/____
M Y M Y

Doctor or Health Care Provider
Name _____ Address _____
Signature _____ Phone (____) _____

* You may include a copy of your immunization record (typically it is an immunization card) if all of the above vaccinations are documented.
 ** Please review the Health Related Issues Form for more information about each immunization.
 ***If, due to medical reasons or personal beliefs, you decide not to get these immunizations, you must sign an immunization waiver form, which can be found at under "Student Life."

Return the completed form to:
Office of Student Life
 1539 E Howard St
 Pasadena, CA 91104

Office Use Only:

Form received by: _____ Date received: _____ Filed by: _____
 Scanned into database by: _____ Date scanned: _____

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