

STUDENT IMMUNIZATION RECORD

INSTRUCTIONS TO PARENT: COMPLETE AND RETURN TO SCHOOL WITHIN **30 DAYS AFTER ADMISSION**. State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission**. The current age/grade specific requirements are available from schools and local health departments. These requirements can only be waived if a properly signed health, religious or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that purpose only. If you have questions regarding immunizations, or how to complete this form, contact your child's school or local health department.

Step 1 PERSONAL DATA		PLEASE PRINT			
Student's Name	Birthdate (MM/DD/YYYY)	Gender	School	Grade	School Year
Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, Zip)			Telephone Number	

Step 2 IMMUNIZATION HISTORY					
List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE A (✓) OR (X) except to answer the question about chickenpox, Tdap, or Td. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.					
TYPE OF VACCINE*	FIRST DOSE MM/DD/YYYY	SECOND DOSE MM/DD/YYYY	THIRD DOSE MM/DD/YYYY	FOURTH DOSE MM/DD/YYYY	FIFTH DOSE MM/DD/YYYY
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) <input type="checkbox"/> Tdap <input type="checkbox"/> Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine <i>Vaccine is required only if your child has not had chickenpox disease. See below:</i>					
Has your child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known: <input type="checkbox"/> YES _____ Year (Vaccine not required) <input type="checkbox"/> NO or Unsure (Vaccine required)			Has your child had a blood test (titer) that shows immunity (had disease or previous vaccination) to any of the following? (Check all that apply) <input type="checkbox"/> Varicella <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Hepatitis B If YES, provide laboratory report(s)		

Step 3 REQUIREMENTS
Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

Step 4 COMPLIANCE DATA
STUDENT MEETS ALL REQUIREMENTS Sign at Step 5 and return this form to school. _____ Or _____
STUDENT DOES NOT MEET ALL REQUIREMENTS Check the appropriate box below, sign at Step 5, and return this form to school. PLEASE NOTE THAT INCOMPLETELY IMMUNIZED STUDENTS MAY BE EXCLUDED FROM SCHOOL IF AN OUTBREAK OF ONE OF THESE DISEASES OCCURS. <input type="checkbox"/> Although my child has NOT received ALL the required doses of vaccine, the FIRST DOSE(S) has/have been received. I understand that the SECOND DOSE(S) must be received by the 90th school day after admission to school this year, and that the THIRD DOSE(S) and FOURTH DOSE(S) if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine. NOTE: Failure to stay on schedule may result in exclusion from school, court action and/or forfeiture penalty. WAIVERS (List in Step 2 above, the date(s) of any immunizations your child has already received) <input type="checkbox"/> For health reasons this student should not receive the following immunizations _____ _____ SIGNATURE - Physician _____ Date Signed _____ <input type="checkbox"/> For religious reasons , I have chosen not to vaccinate this student with the following immunizations (check all that apply) <input type="checkbox"/> DTaP/DTP/DT/Td <input type="checkbox"/> Tdap, <input type="checkbox"/> Polio <input type="checkbox"/> Hepatitis B <input type="checkbox"/> MMR (Measles, Mumps, Rubella) <input type="checkbox"/> Varicella <input type="checkbox"/> For personal conviction reasons , I have chosen not to vaccinate this student with the following immunizations (check all that apply) <input type="checkbox"/> DTaP/DTP/DT/Td <input type="checkbox"/> Tdap <input type="checkbox"/> Polio <input type="checkbox"/> Hepatitis B <input type="checkbox"/> MMR (Measles, Mumps, Rubella) <input type="checkbox"/> Varicella

Step 5 SIGNATURE
This form is complete and accurate to the best of my knowledge. Check one: (I do <input type="checkbox"/> I do not <input type="checkbox"/>) give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR. _____ SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student Date Signed _____