Student Health History and Immunization Form

Please complete all sections of this form. This document is intended for printing and physical submission.

Student Information

First Name: ______ Last Name: ______

Date of Birth (MM/DD/YYYY): ______ Student ID Number: ______

Phone Number: ______ Email Address: ______

Gender: ______

Emergency Contact Information

Contact Name: ______ Relationship to Student: ______

Contact Phone Number: ______

Medical History

Please list any known medical conditions (e.g., Asthma, Diabetes, Epilepsy):

______

Please list any drug, food, or environmental allergies:

______

Please list any medications currently taken on a regular basis:

______

Immunization History

Enter the dates of administration (MM/DD/YYYY) for each required vaccine.

Vaccine Type	Dose 1 Date	Dose 2 Date	Dose 3 Date / Booster Date
MMR (Measles, Mumps, Rubella)			Not Applicable
Tdap (Tetanus, Diphtheria, Pertussis)		Not Applicable	Not Applicable
Hepatitis B			
Varicella (Chickenpox)			Not Applicable
Meningococcal ACWY		Not Applicable	

Verification and Authorization

By signing below, I certify that the information provided on this form is correct and complete to the best of my knowledge.

Signature of Student (or Parent/Guardian if under 18): ______

Date (MM/DD/YYYY): ______