Student Medical History and Immunization Form

Please complete all sections of this form. This form is designed for printing and manual record-keeping.

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1. Student Information

Full Name (Last, First, Middle):	
Date of Birth (MM/DD/YYYY):	
Student ID Number:	
Phone Number:	
Email Address:	
Home Address:	

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2. Emergency Contact Information

Contact Name:	
Relationship to Student:	
Contact Phone Number:	

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3. Medical History

Please list any known medical conditions, allergies, or long-term medications.

Drug / Food / Environmental Allergies:	
Current Medications:	
Chronic Medical Conditions (e.g., Asthma, Diabetes):	

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4. Immunization Record

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

Vaccine Type	Dose 1 Date	Dose 2 Date	Dose 3 Date / Booster
Measles, Mumps, Rubella (MMR):			
Tetanus, Diphtheria, Pertussis (Tdap):			
Hepatitis B:			
Varicella (Chickenpox):			
Meningococcal:			

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5. Healthcare Provider Verification (To be completed by a Physician or Clinic)

Provider Name / Clinic:	
Provider Phone Number:	
Provider Signature (Printed Form):	Sign on printed copy
Date of Verification:	