

North Shore School District
HEALTH SERVICES DEPARTMENT

Name _____ Date of Birth _____

The following immunizations are required. *Month, Day and Year must be specified.*
Please provide exact dates.

DPT/DTAP SERIES	#1_____	#2_____	#3_____	#4_____
DPT/DT Boosters	_____	_____	_____	_____
OPV/IPV Series	#1_____	#2_____	#3_____	#4_____
Hepatitis B Series	#1_____	#2_____	#3_____	#4_____

After twelve (12) months of age:

Live Measles Vaccine	#1_____	#2_____	Disease_____
Live Mumps Vaccine	#1_____	#2_____	Disease_____
Live Rubella Vaccine	#1_____	#2_____	Rubella Titer
MMR Vaccine	#1_____	#2_____	_____

Varicella _____ Had Chicken Pox? Date _____

Tdap Vaccine(Born on or after 1/1/94 and entering 6th grade) _____

Rcommended

HIB Series #1_____ #2_____ #3_____ #4_____

Physician's Name _____ Physician's Signature _____

Address _____ Phone _____ Date _____

This form must be returned to the Health Office before your child may attend school.
Physician's Signature Required.