

ARIZONA SCHOOL IMMUNIZATION RECORD

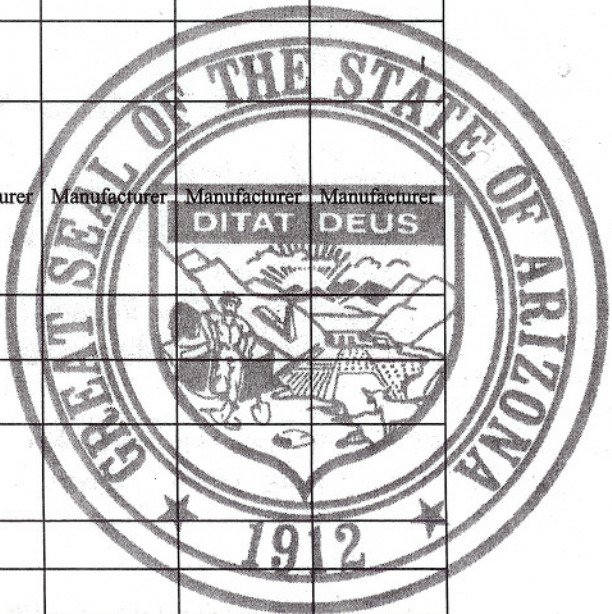
This record is part of the mandatory permanent pupil records as defined in Arizona Revised Statute 15-874 and shall transfer with that record. Local health departments shall have access to this record.

This form must be completed from an immunization record provided by parent or guardian.
See reverse side for instructions.

I. IDENTIFICATION INFORMATION

| | |
|---|---|
| CHILD'S NAME NOMBRE DE NIÑO | BIRTH DATE FECHA DE NACIMIENTO |
| ENTRY GRADE (circle) Pre-K K 1 2 3 4 5 6 GRADO (marque con circulo) 7 8 9 10 11 12 | SEX Male <input type="checkbox"/> Female <input type="checkbox"/> SEXO Niño <input type="checkbox"/> Niña <input type="checkbox"/> |

| II. IMMUNIZATIONS | 1st MO/DAY/YR | 2nd MO/DAY/YR | 3rd MO/DAY/YR | 4th MO/DAY/YR | 5th MO/DAY/YR | 6th MO/DAY/YR |
|--|------------------|------------------|------------------|------------------|------------------|------------------|
| (DTaP/DTP) Diphtheria, Tetanus & Pertussis Difteria, Tetano y Tos Ferina | | | | | | |
| (DT) Diphtheria & Tetanus Difteria y Tetano | | | | | | |
| (Td) Tetanus & Diphtheria Tetano y Difteria | | | | | | |
| (Tdap) Tetanus, Diphtheria, acellular Pertussis Tetano, Difteria y Tos Ferina | | | | | | |
| (IPV/OPV) Polio Vaccine Vacuna Antipoliomielítica | | | | | | |
| (MMR) Measles, Mumps & Rubella Sarampión, y Paperas, y Rubéola (Month, Day & year required) | | | | | | |
| (Hib) Haemophilus Influenzae b Required for Pre-K program, children age 2 months to age 5 years. Influenzae Haemophilus tipo B Los Niños 2 meses de edad a 5 años de edad necesitan tener la vacuna para poder atender la programa de pre-jardin de infantes. | Manufacturer | Manufacturer | Manufacturer | Manufacturer | | |
| (Hep B) Hepatitis B La Vacuna Hepatitis B | | | | | | |
| (Hep A) Hepatitis A La Vacuna Hepatitis A | | | | | | |
| Varicella (Chickenpox) Varicella Check box if history of disease. <input type="checkbox"/> | | | | | | |
| Meningococcal Meningococicas | | | | | | |
| HPV (Human Papilloma Virus) Virus Papilloma Humano | | | | | | |
| Other | | | | | | |
| TB Skin Test: (optional) List most recent test Prueba de tuberculosis del piel: (opcion) Liste la más reciente prueba | | | | | | |



FOR SCHOOL USE ONLY:

| Enrollment Date: _____ | | | | | | |
|--|-----|-----|-----|-----|-----|-----|
| Schedule for Completion (Check dose(s) needed) | | | | | | |
| VACCINE | 1ST | 2ND | 3RD | 4TH | 5TH | 6TH |
| DTap/DTP/DT/Td/Tdap | | | | | | |
| OPV/IPV | | | | | | |
| MMR | | | | | | |
| Hib | | | | | | |
| HPV | | | | | | |
| Hep A | | | | | | |
| Hep B | | | | | | |
| Mening | | | | | | |
| VAR | | | | | | |

III. Documentation

I certify that I reviewed this student's immunization record and it has been transcribed accurately.

Date _____/_____/_____
Admitting Official _____

Documentation presented:

- Arizona Lifetime Record
- Foreign country (name) _____
- Out-of-State record (name) _____
- Other (name) _____

IV. Status of Requirements

- A. Immunization complete Date ___/___/___
- B. Currently up-to-date; more doses are due later. Needs follow-up.
- C. Laboratory evidence of immunity to: _____

Exemption for:

- D. Medical Reasons-Permanent
Date ___/___/___
- E. Medical Reasons-Temporary until
Date ___/___/___
- F. Personal Beliefs
Date ___/___/___