

IMMUNIZATION RECORD

Must be completed and returned with the "Personal Health & Medical" form for Campers

| | | |
|-----------------------------------|---------------------------|-------------------------|
| Name of Child (Last, First, M.I.) | Date of Birth (Mo/Day/Yr) | Sex Male Female |
|-----------------------------------|---------------------------|-------------------------|

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|-----------------------------------|-----------------|---------------|
| PARENT OR GUARDIAN | NAME ADDRESS | TELEPHONE NO. |
|-----------------------------------|-----------------|---------------|

| VACCINE TYPE | DISEASE DATE | 1st Dose Mo/Day/Yr | 2nd Dose Mo/Day/Yr | 3rd Dose Mo/Day/Yr | 4th Dose Mo/Day/Yr | 5th Dose Mo/Day/Yr | Mo/Day/Yr |
|---|-----------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------|
| DIPHTHERIA, TETANUS, PERTUSSIS - DTP <i>*If DT or Td, indicate in box</i> | | | | | | | |
| POLIO, ORAL POLIO VACCINE (OPV) <i>*If Salk Vaccine, indicate (IPV) in box</i> | | | | | | | |
| MEASLES, MUMPS, RUBELLA (MMR) | | | | | Serology | | |
| MEASLES | | | | | Measles | Date | Titer |
| RUBELLA | | | | | Rubella | Date | Titer |
| MUMPS | | | | | Mumps | Date | Titer |
| HAEMOPHILUS B (HIB) | | | | | | | |
| HEPATITIS B | | | | | Hepatitis B | Date | Titer |
| VARICELLA | | | | | Varicella | Date | Titer |
| <i>Other (Specify)</i> | | | | | | | |
| <i>Other (Specify)</i> | | | | | | | |