



**HISTORY OF IMMUNIZATIONS AND TEST** (indicate month / day / year)

	1	2	3	4	5
<b>DTaP / DT</b>					

	1	2	3	4
<b>Hib</b>				

	1	2	3	4	5
<b>IPV (Pollo)</b>					

	1	2	3	4	5
* <b>Influenza (Flu)</b>					

	1	2
<b>Measles Mumps Rubella (MMR)</b>		

	1	2	3
<b>Rotavirus (RGE)</b>			

	1	2	or Chicken Pox Disease	Month / year
<b>Varicella (Varivax)</b>				

	1	2	3	4
<b>Pneumococcal (PCV) (Pevnar)</b>				

	1	2
<b>HEP A</b>		

	1	2	3
<b>HBV (HEP B)</b>			

\* Recommended yearly.

Name of physician / nurse practitioner completing form (please print)

Telephone number

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Signature of physician / nurse practitioner

**ADDITIONAL NOTES AND INSTRUCTIONS**

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