REV 4/15

LACORDAIRE ACADEMY

IMMUNIZATION REGISTRY NUMBER

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

PARENT OR GUARDIAN	NAME	TELEPHONE NO.
	ADDRESS	

VACCINE TYPE	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	LEAD SCREENING	
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT, indicate)						**Test Date**	**Result**
Tdap							
POLIO – INACTIVATED POLIO VACCINE (IPV) If oral vaccine, indicate (OPV)							
MEASLES, MUMPS, RUBELLA (MMR)					**Document below single antigen vaccine receipt, Serology titers, or varicella disease history**		
HAEMOPHILUS B (HIB)					Hepatitis B	Date:	Titer:
HEPATITIS B					Varicella	Date:	Titer:
VARICELLA					Measles	Date:	Titer:
PNEUMOCOCCAL CONJUGATE**					Mumps	Date:	Titer:
MENINGOCOCCAL					Rubella	Date:	Titer:
HEPATITIS A***							
HPV (HUMAN PAPILLOMAVIRUS)***							
OTHER, SPECIFY:							

☐ Provisional admission attached – Date Granted:_____ ☐ Medical exemption attached ☐ Religious exemption attached

** REQUIRED FOR DAY/CHOLD CARE ENROLLEES (2 Months-5th Birthday Only) *** Not Required

_____ M.D.

Address: _____

_____

Phone: _____

MD OFFICE STAMP