



Immunization Documentation

Name: _____ Date: _____

School: _____

Date

MMR (Measles, Mumps, Rubella) Vaccination (1st)
MMR (Measles, Mumps, Rubella) Vaccination (2nd)
OR
Titer Showing Immunity

AND

Chicken Pox (Varicella) Vaccination (1st)
Chicken Pox (Varicella) Vaccination (2nd)
OR
Titer Showing Immunity

AND

Non-reactive TB test (0 mm PPD) within past 12 months
OR
if positive PPD, medical clearance within past 12 months

Printed Name & Signature of School Nurse or Health Care Provider