**INTERNATIONAL STUDENT IMMUNIZATION RECORD ’18 -‘19**

**This record must be completed by a physician from an immunization record provided by a parent or guardian. Dates must include the month, day and year.**

Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M  F  Birthdate (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| **California Dept of Public Health / ShotsForSchool.org****VACCINE** | **Date each dose given** |
| **1st** | **2nd** | **3rd** | **4th** | **5th** |
| **MM/DD/YYYY** | **MM/DD/YYYY** | **MM/DD/YYYY** | **MM/DD/YYYY** | **MM/DD/YYYY** |
| **Polio** **Myelitis** **3 dose minimum** (the last dose must be on or after the 2nd birthday). If not, 4 doses needed | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |
| **DTP/DTaP/Td** Diphtheria, Tetanus, & Pertussis**3 dose minimum** (the last dose must be on or after the 2nd birthday). If not, 4 doses needed | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |
| **Tdap/Boostrix/Adacel** Tetanus Toxoid, Reduced Diphtheria Toxoid & Acellular Pertussis **1 dose required** (on or after 7th birthday). This will meet (1) DTP dose requirement | \_\_\_/\_\_\_/\_\_\_\_\_ | **STUDENT CAN RECEIVE Tdap AFTER ARRIVING IN CALIFORNIA** |
| **MMR** combined immunization for Measles, Mumps & Rubella **1 dose minimum** (on or after 1st birthday) If not, 2 doses needed. | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |  |
|  **Measles** Rubeola – 10 day Measles  **1 dose minimum** (on or after 1st birthday) If not, 2 doses needed. | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | Physician documented Measles disease history meets requirement\_\_\_/\_\_\_/\_\_\_\_\_ (date of Measles disease) |
|  **Mumps** not required for grades 9-12 | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ (date of Mumps disease) |
|  **Rubella** German Measles – 3 day Measles **1 dose minimum** (on or after 1st birthday) If not, 2  doses needed. | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | Physician documented Rubella disease history meets requirement\_\_\_/\_\_\_/\_\_\_\_\_ (date of Rubella disease) |
| **Varicella** (Chickenpox) **2 dose minimum**for ages 13 – 17 years old | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | Physician documented Chicken Pox disease history meets requirement\_\_\_/\_\_\_/\_\_\_\_\_ (date of Chicken Pox disease) |
| **BCG** Tuberculosis vaccine (not required) | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | **REQUIRED**-most recent test: Positive  Normal PPD-Mantoux \_\_\_/\_\_\_/\_\_\_ Negative  CXR \_\_\_/\_\_\_/\_\_\_ Abnormal  |
| PHYSICIAN’S NAME (please type or print): | PHYSICIAN’S SIGNATURE: | DATE: | PHYSICIAN’S STAMP/SEAL (REQUIRED): |
| ADDRESS: | PHONE: |

Record presented was: \_\_\_\_\_ Yellow CA Immunization Record \_\_\_\_\_ CSIR \_\_\_\_\_ Out-of-State School Record \_\_\_\_ MD translated Record \_\_\_\_Other Immunization Record

OVER

**INTERNATIONAL STUDENT IMMUNIZATION RECORD**

**This record must be completed by a physician from an immunization record provided by a parent or guardian. Dates must include the month, day and year.**

|  |  |
| --- | --- |
| **VACCINE** | **Date each dose given** |
| **1st** | **2nd** | **3rd** | **4th** | **5th** |
| **MM/DD/YYYY** | **MM/DD/YYYY** | **MM/DD/YYYY** | **MM/DD/YYYY** | **MM/DD/YYYY** |
| **Hepatitis B** 3 doses recommended | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |
| **Hepatitis A** | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |
| **Meningococcal / Meningitis** 1 dose recommended for college admission | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |
| **Pneumococcal** | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |
| **HPV (Human Papillomavirus)**  | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |
| **Influenza** | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |
| **Encephalitis B** | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |
| **JE (Japanese Encephalitis)** | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |
| Other | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |
| Other | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |
| Other | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |
| Other | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |
| PHYSICIAN’S NAME (please type or print): | PHYSICIAN’S SIGNATURE: | DATE: | PHYSICIAN’S STAMP/SEAL (REQUIRED): |
| ADDRESS: | PHONE: |

Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M  F  Birthdate (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER IMMUNIZATIONS (NOT REQUIRED)**