**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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)**