

Student's Name: _____ Date of Birth: _____ Grade: _____
 Parent / Guardian: _____ Phone: _____

ACADEMY OF THE HOLY FAMILY
 REQUIRES THIS FORM TO BE COMPLETED AND PROVIDED TO THE SCHOOL PRIOR TO ACCEPTANCE
 Enter date (month/day/year) each immunization was given and circle which vaccine was given.

VACCINE	Dose 1 (Month/Day/Year)	Dose 2 (Month/Day/Year)	Dose 3 (Month/Day/Year)	Dose 4 (Month/Day/Year)	Dose 5 & 6 (Month/Day/Year)
Hep B (Hepatitis B) (3 Doses Required)	____/____/____	(Dose 2 must be given at least 4 weeks after Dose 1) ____/____/____	(Dose 3 must be given at least 8 weeks after Dose 2 and at least 16 weeks after Dose 1) ____/____/____	____/____/____	Written evidence of Laboratory Test showing immunity to Hepatitis B is Acceptable
DTP or DTaP Diphtheria-Tetanus-Pertussis (4 Doses Required with last dose given on or after 4 th birthday) DTaP vaccine is not given on after 7 th birthday	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____ ____/____/____
Tdap or Td or DP (Tetanus-Diphtheria) (1 Dose Required every 10 years)	____/____/____	____/____/____	____/____/____	Tdap is given for those who have completed the childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoid (Td) booster dose. Tdap is only licensed for one dose.	
Hib (H. Influenza) (Not given for children 5 years old or old)	____/____/____	____/____/____	____/____/____		
OPV or IPV (Oral or Inactive Polio) Oral Polio Vaccine is no longer given in the United States (3 doses required with last dose given on or after 4 th birthday)	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Measles or MMR/MMRV (Measles, Mumps, Rubella / Varicella) (2 doses required)	(1 st dose must be on or after 1 st birthday) ____/____/____	(2 nd dose required) ____/____/____	____/____/____	Written evidence of Laboratory Test showing immunity to Measles is Acceptable	
Mumps or MMR/MMRV (Measles, Mumps, Rubella / Varicella) (2 doses required)	(1 st dose must be on or after 1 st birthday) ____/____/____	(2 nd dose required) ____/____/____	____/____/____	Written evidence of Laboratory Test showing immunity to Mumps is Acceptable	
Rubella or MMR or MMRV (Measles, Mumps, Rubella / Varicella) (2 doses required)	(1 st dose must be on or after 1 st birthday) ____/____/____	(2 nd dose required) ____/____/____	____/____/____	Written evidence of Laboratory Test showing immunity to Rubella is Acceptable	
Varicella or MMRV (Chicken Pox / Measles, Mumps, Rubella, Chicken Pox) (2 doses required)	(1 st dose must be on or after 1 st birthday) ____/____/____	(2 nd dose required) ____/____/____	____/____/____	Written evidence of Laboratory Test showing immunity to Chicken Pox is Acceptable	
Meningococcal (1 dose required)	____/____/____				
Influenza (Yearly)	____/____/____	____/____/____	____/____/____		
Hep A (Hepatitis A) (Recommended)	____/____/____	____/____/____	____/____/____		
HPV (Human papillomavirus)	____/____/____	____/____/____	____/____/____		
TB (Tuberculosis) (Mantoux or blood test) (Required)	____/____/____ + -- If Positive results must have a chest x-ray	____/____/____ + -- If Positive results must have a chest x-ray	____/____/____ + -- If Positive results must have a chest x-ray	____/____/____ + -- If Positive results must have a chest x-ray	____/____/____ + -- If Positive results must have a chest x-ray
Other (Name)	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____

Health Care Provider's (MD, PA, or APRN) Signature: _____ Date: _____