



Program: 2018 High School Summer Program – Putney Campus

From: Health Services

Re: Immunization History

Last name First name Middle (Chosen Name) Birth Date Mobile #

Immunization History

Provide the month and year for each immunization. Immunizations with an asterisk (*) must include date to meet American Camp Association standards. Copies of immunizations forms from health care providers or state and local government are acceptable; please attach to this form.

Immunization	Dose 1 (mm/yyyy)	Dose 2 (mm/yyyy)	Dose 3 (mm/yyyy)	Dose 4 (mm/yyyy)	Dose 5 (mm/yyyy)	Most recent dose (mm/yyyy)
Diphtheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Polio (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	☐ Had chicken pox Date:					
Meningococcal meningitis (MCV4)						

Acknowledgement

If your student has not been fully immunized, please sign below to acknowledge that **you understand and accept the risks to my child from not being fully immunized.**

Parent/Family/Guardian printed name

Date

Signature