Plymouth Community School Corporation
School Entrance Health Form

To be completed by physician, registered nurse, or health department official.

(A copy of the immunization record signed or stamped by a physician or designee indicating the dates of administration including month, day and year of required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.)

Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name: _____ *Last* *First* *Middle*					Date of Birth: _____/_____/_____ *Mo.* *Day* *Yr.*
IMMUNIZATION	**RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN**				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6th grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <2 years of age	1	2	3	4	
*Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1	2	Serological Confirmation of Measles Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV)	1	2	3	4	
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
*Hepatitis A Vaccine	1	2			
*Meningococcal Vaccine	1				

*Human Papillomavirus Vaccine	1	2	3		
*Other	1	2	3	4	5
*Other	1	2	3	4	5

I certify that this child is **ADEQUATELY OR AGE APPROPRIATE IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care, or preschool prescribed by the State Board of Health's Regulations for the Immunization of School Children.
Signature of Medical Provider or Health Department Official _____
Date (Mo., Day, Yr.): _____/_____/_____