

# MAUMEE CITY SCHOOLS IMMUNIZATION RECORDS

Student Name:

Birthdate

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DAY MONTH YEAR

SCHOOL

GRADE

IMMUNIZATIONS	Date	Date	Date	Date	Date
DTaP/DTP/DT/Td					
POLIO					
MMR					
HIB					
HEP B					
VARICELLA					
TB TEST	Date	Result			

Parent Signature:	Date:
Physician Signature:	Date:
Physician Name: (PLEASE PRINT)	Address: