PROVIDENCE
CHRISTIAN COLLEGE

# Immunization Record Form

**This form should be completed and signed by your doctor or health care provider.**

Name _____
(Last Name) (First Name)

## Immunization Record*

**Hepatitis B Vaccine****
Dose #1 _____/_____ Dose #2 _____/_____ Dose #3 _____/_____
M Y M Y M Y

**MMR (Measles, Mumps, Rubella) Vaccine**
Dose #1 _____/_____ Dose #2 _____/_____
M Y M Y

**Tetanus-Diphtheria Vaccine**
Dose #1 _____/_____ Dose #2 _____/_____ Dose #3 _____/_____
M Y M Y M Y
Td booster (within the last ten years) _____/_____
M Y

**Varicella Vaccine or History of Chickenpox**
a. History of Disease _____Yes _____No
b. Vaccine (if no history of disease)
Dose #1 _____/_____ Dose #2 (if applicable) _____/_____
M Y M Y

**Doctor or Health Care Provider**

Name_____ Address_____

Signature_____ Phone (____)_____

* You may include a copy of your immunization record (typically it is an immunization card) if all of the above vaccinations are documented.
** Please review the Health Related Issues Form for more information about each immunization.
***If, due to medical reasons or personal beliefs, you decide not to get these immunizations, you must sign an immunization waiver form, which can be found at www.providencecc.net under "Student Life."

Return the completed form to:
***Office of Student Life***.
1539 E Howard St
Pasadena, CA 91104

**Office Use Only:**

Form received by: _____ Date received: _____ Filed by: _____

Scanned into database by: _____ Date scanned: _____