PROVIDENCE
CHRISTIAN COLLEGE

Immunization Record Form

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

Immunization Record*

Name_____
(Last Name) (First Name)

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
History of Disease _____Yes _____No

Vaccine (if no history of disease)
Dose #1 _____/_____ Dose #2 (if applicable) _____/_____
M Y M Y

<u>Doctor or Health Care Provider</u>

Name_____ Address_____

Signature_____ Phone (_____)_____

* If all of the above vaccinations are documented, an immunization record may be submitted in lieu of this form.
* If you have not acquired vaccinations due to personal beliefs, please complete the Immunization Waiver Form.

Return completed form to:

Office of Student Life
Providence Christian College
464 E. Walnut St.
Pasadena, CA 91101

Office Use Only:

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

Scanned in database by: _____ Date scanned: _____