



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 ____/____ M Y Dose #2 ____/____ M Y Dose #3 ____/____ M Y

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

Tetanus-Diphtheria Vaccine
 Dose #1 ____/____ M Y Dose #2 ____/____ M Y Dose #3 ____/____ 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 ____/____ M Y Dose #2 (if applicable) ____/____ M Y

Doctor or Health Care Provider

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: _____