Livonia Central School

MUST BE COMPLETED BY YOUR PHYSCIAN OR SUBMIT A COPY OF IMMUNIZATIONS FROM YOUR PHYSICIAN

Student Name: _____

Immunization History	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
DPT, DT	*	*	*	*	*
Tdap	*				
Polio	*	*	*	*	*
MMR	*	*			
Hepatitis B	*	*	*		
HIB	*	*	*		
Hepatitis A					
Chicken Pox/Varicella	*	*	**☐had disease** **Date:**		
Prevnar (Pneumococcal)	*	*	*	*	
Meningitis	*				
HPV					
Exemptions:	**☐ medical**	**☐ religious**			

***immunization is required**

Additional space, if needed:

_____

_____

_____

_____

Provider Signature _____

Date_____

REVISED
3:13 pm, May 17, 2017