**DEPARTMENT OF HEALTH & FAMILY SERVICES**
Division of Public Health
DPH 4020L (Rev. 02/08)

**STATE OF WISCONSIN**
252.04 and 120.12 (16) Wis. Stats.

# STUDENT IMMUNIZATION RECORD

**INSTRUCTIONS TO PARENT:** COMPLETE AND RETURN TO SCHOOL WITHIN **30 DAYS AFTER ADMISSION**. State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission**. The current age/grade specific requirements are available from schools and local health departments. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that reason only. If you have questions on immunizations or how to complete this form, contact your child's school or local health department.

**PERSONAL DATA** **PLEASE PRINT**

**Step 1**

| Student's Name | Birthdate (Mo/Day/Yr) | Gender | School | Grade | School Year |
|---|---|---|---|---|---|
| | | | | | |

| Name of Parent/Guardian/Legal Custodian | Address (Street, City, State, Zip) | Telephone Number ( ) |
|---|---|---|
| | | |

**IMMUNIZATION HISTORY**

**Step 2**

List the MONTH, DAY AND YEAR your child received each of the following immunizations. DO NOT USE A (√) OR (X) except to answer the question about chickenpox. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.

| TYPE OF VACCINE* | FIRST DOSE Mo/Day/Yr | SECOND DOSE Mo/Day/Yr | THIRD DOSE Mo/Day/Yr | FOURTH DOSE Mo/Day/Yr | FIFTH DOSE Mo/Day/Yr |
|---|---|---|---|---|---|
| DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis) | | | | | |
| Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td | | | | | |
| Polio | | | | | |
| Hepatitis B | | | | | |
| MMR (Measles, Mumps, Rubella) | | | | | |
| Varicella (Chickenpox) Vaccine Vaccine is required only if your child has not had chickenpox disease. See below: | | | | | |

*Hib vaccine is only required for children in licensed day care centers. Do not report the dates your child received Hib vaccine on this form.

Has your child had Varicella (chickenpox) disease? Check the appropriate box And provide the year if known:
☐ YES _____ year (Vaccine not required)
☐ NO or Unsure (Vaccine required)

**REQUIREMENTS**

**Step 3**

Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

**COMPLIANCE DATA**

**Step 4**

**STUDENT MEETS ALL REQUIREMENTS**
Sign at Step 5 and return this form to school.

—— Or ——

**STUDENT DOES NOT MEET ALL REQUIREMENTS**

Check the appropriate box below, sign at Step 5, and return this form to school. PLEASE NOTE THAT INCOMPLETEY IMMUNIZED STUDENTS MAY BE EXCLUDED FROM SCHOOL IF AN OUTBREAK OF ONE OF THESE DISEASES OCCURS.

☐ Although my child has NOT received ALL required doses of vaccine, the FIRST DOSE(S) has/have been received. I understand that the SECOND DOSE(S) must be received by the 90th school day after admission to school this year, and that the THIRD DOSE(S) and FOURTH DOSE(S) if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

**NOTE: Failure to stay on schedule and notify the school may result in court action and a fine of up to $25.00 per day of violation.**

**WAIVERS** (List in Step 2 above, the date(s) of any immunizations your child has already received)

☐ **For health reasons** this student should not receive the following immunizations_____

_____ _____
**SIGNATURE** - Physician Date Signed

☐ **For religious reasons** this student should not be immunized.

☐ **For personal conviction reasons** this student should not be immunized.

_____
**LIST VACCINE(S) WAIVED**

**SIGNATURE**

**Step 5**

This form is complete and accurate to the best of my knowledge.

_____ _____
**SIGNATURE** - Parent/Guardian/Legal Custodian or Adult Student Date Signed