HEARING @ 25 dB				
DATE: _____ SIGNATURE: _____				
Hz	1000	2000	4000	☐ Pass
R				☐ Fail
L				
VISION				
DATE: _____ SIGNATURE: _____				
R20/ _____ L20/ _____ Pass _____ Fail _____				

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA privacy notice.

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Department of State Health Services
Immunization Unit

Stock No. C-11 Revised 07/2017

School / Child-care Immunization Record

Name: _____ Sex: ☐ M ☐ F

Date of Birth: _____ Telephone No.: _____

Street Address: _____

City, State, Zip Code: _____

School: _____

Parent's Name: _____

PARENT/PHYSICIAN'S VERIFICATION OF VARICELLA (CHICKENPOX) ILLNESS

This is to verify the person for whom this card was issued had:

☐ Varicella (chickenpox) illness on or about _____ and does not need the vaccine.

_____ _____

Date Parent / Physician's Signature

Name: _____ Date of Birth: _____

VACCINES	DATE	DATE	DATE	DATE	DATE
Hepatitis B					
DTP/DTaP/DT					
Tdap					
Td					
OPV, IPV					
Hib					
Pneumococcal					
Rotavirus					
HPV					
MMR					
Hepatitis A					
Varicella					
MenACWY					
MenB					
Influenza					
Influenza					
Other					
Other					
Other					
TB Test _____		Date: _____		Result: _____	

Date: _____ Staff Signature: _____

Record hearing and vision on reverse.