Greenwich Township School District
Vaccination Record

To be completed by parent/guardian:

Pupil Name: ____________ DOB: ______ Grade: ______ Gender: ______

Physician Name: ____________ Telephone Number: ____________

To be completed by physician:

Please list month, day and year of each vaccination.

DTP (Diptheria, Tetanus, Pertussis): 4 doses one being on or after the fourth birthday or 5 doses required.

Date Dose 1: ____________ Date Dose 2: ____________ Date Dose 3: ____________

Date Dose 4: ____________ Date Dose 5: ____________

Polio: 3 doses one being on or after the fourth birthday or 4 doses required.

Date Dose 1: ____________ Date Dose 2: ____________ Date Dose 3: ____________

Date Dose 4: ____________

Hepatitis B: 3 doses required.

Date Dose 1: ____________ Date Dose 2: ____________ Date Dose 3: ____________

MMR (Measles, Mumps, Rubella): 2 doses separated by at least one month and both after first birthday required.

Date Dose 1: ____________ Date Dose 2: ____________

Varicella (Chicken Pox): 1 dose after first birthday required.

Date Dose 1: ____________

Pneumococcal: 1 dose after first birthday required if entering kindergarten at age 4.

Date Dose 1: ____________

Haemophilus Influenza B (HIB): 1 dose after first birthday required if entering kindergarten at age 4.

Date Dose 1: ____________

Influenza (Flu): 1 dose between September 1 and December 31 for preschool students.

Date Dose 1: ____________

Physician Signature: ____________________ Date: ____________