URJ **Youth**

Patient's Name

Last _____ First _____ Middle _____

Date of Birth _____ Gender _____ Session _____

IMMUNIZATION HISTORY

Immunization	Dose 1 Day/Month/Year	Dose 2 Day/Month/Year	Dose 3 Day/Month/Year	Dose 4 Day/Month/Year	Dose 5 Day/Month/Year	Most Recent Dose Day/Month/Year
Diptheria, tetanus, pertussis (DTaP) or (Tdap)						
Tetanus booster (Td) or (Tdap)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						
Rotavirus (Recommended, not required)						
Gardasil (Recommended, not required)						
Flu vaccine (Recommended, not required)						

Please note: This form may only be signed by a licensed Physician, Nurse Practitioner, or Physician Assistant.

I have reviewed and completed the vaccination history as per patient's record and confirm that the patient is up to date with all age appropriate vaccinations. I have been this applicants health care provider for _____ years.

Examining Physician/NP/PA Signature | Print | Date

Address | City, State/Province, Zip/Postal Code | Telephone

Stamp here for Medical Office Authorization: