WESTFIELD PUBLIC SCHOOLS, Westfield, New Jersey

MEDICAL RECORD FORM

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

ADDRESS _____ PHONE NUMBER _____ DATE OF BIRTH _____

TO BE FILLED OUT BY EXAMINING PHYSICIAN PLEASE GIVE EXACT DATE OF IMMUNIZATION

Vaccine Type	1ST DOSE MO/DAY/YR	2ND DOSE MO/DAY/YR	3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YR	5TH DOSE MO/DAY/YR	6TH DOSE MO/DAY/YR
DIPHTHERIA, TETANUS, PERTUSSIS (If TD, DTaP, or DT*, indicate in corner box)						
POLIO- ORAL POLIO VACCINE (OPV) (If Salk Vaccine, indicate IPV in corner box)						
MEASLES, MUMPS, RUBELLA (MMR)						
MEASLES				or Measles Serology	Date	Titer
RUBELLA				or Rubella Serology	Date	Titer
MUMPS				or Mumps Serology	Date	Titer
HAEMOPHILUS B (HIB)						
HEPATITIS A						
HEPATITIS B						
VARICELLA						
INFLUENZA (Annual in Pre-K)						
MANTOUX DATE\RESULTS						
OTHER						
OTHER						
MENINGOCOCCAL VACCINE						
PREVNAR (Once in Pre-K)						

☐ Medical Exemption Attached

☐ Religious Exemption Attached

_____ _____

Physician's Signature & Stamp **Date of Exam**

Apr-08