Immunization Form

Student information	
Name of student: Jack Benn	Date of birth: 01/15/2010
Gender: Male	Name of parent: Jane Benn
Email: janedoe@example.com	Contact: (555) 123-4567
Address: 123 Maple Street, Springfield, IL	

Immunization	**Date**
Diphtheria	01/05/2020
Tetanus	01/05/2020
Pertussis	
Polio (PV)	05/22/2018
Measles	
Mumps	03/11/2019
Rubella	03/11/2019
Hepatitis B	07/30/2018
Varicella (Chickenpox)	
Haemophilus Influenzae Type B (Hib)	
Pneumococcal Conjugate (PCV)	
COVID-19	12/01/2021 (last dose)
Influenza (Flu)	
Other vaccinations:	

Health professional's information	
Name: Dr. Emily Smith	License number: 12345-6789
Contact: (555) 987-6543	

Parent/Guardian acknowledgment	
I, the undersigned, confirm that the information provided above is accurate and authorize the release of my child's immunization record to the school.	
Parent/Guardian signature: JANE BENN	Date: 01/10/2023
Healthcare of professional's signature: DR. EMILY SMITH	