student:							
JDENT LAST NAME	STUDE	STUDENT FIRST NAME			TE OF BIRTH (MM/DD/YY		
eck ONE of the following o	ptions:						
most recent immunization record. obtain on provider. be found			o not have a copy, you can probably in through your school or healthcare legible on your submitted copy, you do not need to include this page.				
OR	web accounts for students.						
I will provide immunization information on the form below.	,						
Immunization record (con	nplete only if NO					1	
Vaccine	Date each dos			s given	(mm/dd/yy)	5th	
Polio POV or IPV	/ /	/ /	/ /	/	/ /	/ /	
Diptheria, tetanus, pertussis DTaP, DPT, DT	/ /	/ /	/ /	/	/ /	/ /	
SARS-CoV-2 (COVID-19)	/ /	/ /	/ /	/	If the student received a combined		
Measles	/ /	/ /		If the			
Mumps	/ /	/ /		rube and	ine—such as meas ella (MR) or measle rubella (MMR)—e	measles, mumps R)—enter the	
Rubella	/ /	/ /		samo	e date in each appr	opriate box.	
Chickenpox Varicella	/ /	/ /	/				
Tuberculosis skin test Most recent test only	/ /	Induration	Impressi □ POSIT _ mm □ NEGA	IVE	X-ray date (if pos)	Impression 2 POSITIVE NEGATIVE	
By signing, I attest that I have provided this student's immunization record as	YOUR NAME SIGNATURE				RELATION TO STUI	DENT	
completely and accurately as possible.	SIGNATURE				DATE /	/	

Submit this form or a copy of your immunization records:

BY MAIL

Mail to:

University of California, Berkeley Academic Talent Development Program Graduate School of Education 70 University Hall #1160 Berkeley, CA 94720-1160

BY FAX

Fax to:

510-642-0510

Don't have a fax machine? There are many free online fax services that allow you to submit a legible PDF, such as faxzero.com.

Can't 1 email it? To help protect the privacy of your student's medical records, we advise submitting your immunization records via hard copy only.