Yellow Card

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IMMUNIZATION RECORD
Comprobante de inmunización

CAIR ID#: 269264 Med Rec#: 794722

Name *nombre* TAZHNAE BROOKS

Birthdate *fecha de nacimiento* 08/25/2002 **Sex** *sexo* Female

Allergies *alergias*

Vaccine Reactions *reacciones de la vacuna*

History of Chickenpox *historia de varicela* No **Date Printed** 05/21/2020

RETAIN THIS DOCUMENT - *CONSERVE ESTE DOCUMENTO*

VACCINE *vacuna*	DATE GIVEN *fecha de vacunación*	DOCTOR OFFICE OR CLINIC *médico o oficina*	DATE NEXT DOSE DUE *próxima vacuna*
POLIO (1) Polio-Inject	11/18/2002	Transcribed By (CA IMMUNIZATION PROGRAM)	
(2) Polio-Inject	05/14/2003	VALLEY HEALTH CENTER PRIMARY CARE	
(3) Polio-Inject	06/23/2003	EAST VALLEY PEDIATRICS	
(4) Polio-Inject	07/21/2008	EASTMONT WELLNESS CENTER	
DTP (1) DTaP	11/18/2002	Transcribed By (CA IMMUNIZATION PROGRAM)	
(2) DTaP	05/14/2003	VALLEY HEALTH CENTER PRIMARY CARE	
(3) DTaP	06/23/2003	EAST VALLEY PEDIATRICS	
(4) DTaP	01/27/2004	EAST VALLEY PEDIATRICS	
(5) DTaP	07/21/2008	EASTMONT WELLNESS CENTER	
Tdap (1) Tdap	02/20/2014	34580CHILDRENS HOSPITAL OAKLAND PRIMARY CARE	02/20/2024
HIB (1) HepB-Hib	11/18/2002	Transcribed By (CA IMMUNIZATION PROGRAM)	
(2) HepB-Hib	05/14/2003	VALLEY HEALTH CENTER PRIMARY CARE	
(3) HepB-Hib	06/23/2003	EAST VALLEY PEDIATRICS	
(4) Hib, NOS	01/27/2004	EAST VALLEY PEDIATRICS	
MMR (1) MMR	08/25/2003	EAST VALLEY PEDIATRICS	
(2) MMR	07/21/2008	EASTMONT WELLNESS CENTER	
HEPB (1) HepB-Peds	09/09/2002	Transcribed By (CA IMMUNIZATION PROGRAM)	
(2) HepB-Hib	11/18/2002	Transcribed By (CA IMMUNIZATION PROGRAM)	
(3) HepB-Hib	05/14/2003	VALLEY HEALTH CENTER PRIMARY CARE	
PneumoConjugate (1) PCV7	11/18/2002	Transcribed By (CA IMMUNIZATION PROGRAM)	
(2) PCV7	05/14/2003	VALLEY HEALTH CENTER PRIMARY CARE	
(3) PCV7	01/27/2004	EAST VALLEY PEDIATRICS	
PneumoPolysaccharide			
VZV (1) Varicella	08/25/2003	EAST VALLEY PEDIATRICS	
(2) Varicella	07/21/2008	EASTMONT WELLNESS CENTER	

TB Tests *Prueba de TB*	Type*	Date Given	Given By	Date Read	Read By	Results	Interpretation

* Only the three most recent TB tests are shown.

* If required for school entry, must be Manitoux unless exception granted by local health dept.

CHEST X-RAY
Film date: _____ Interpretation: ☐ normal ☐ abnormal
Person is free of communicable tuberculosis: ☐ yes ☐ no
Signature/Agency:

Parents: Your child must meet California 8 immunization requirements to be enrolled in school.
Keep this record as proof of immunization.
Su hijo debe cumplir con los requisitos de vacuna para a la escuela. Mantenga este

DTP = diptheria, tetanus, pertussis (whooping cough) *difteria , tétanos , y tos ferina*
Hib Hib menengitis (Haemophilus Influenza B) *menengitis Hib*
PM 298 (7/98)

MMR = measles, mumps, rubella *paperas sarampión Rubéola*
HEPB = hepatitus B

VZV = varicella (chickenpox) *varicela*
() indicates a dose number in a series

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CAIR ID#: 269264 Med Rec#: 794722

IMMUNIZATION RECORD Continuation Form

Comprobante de Inmunización - Pagina de Continuación

Name
nombre TAZHNAE BROOKS

VACCINE *vacuna*	DATE GIVEN *fecha de vacunación*	DOCTOR OFFICE OR CLINIC *médico o oficina*	DATE NEXT DOSE DUE *próxima vacuna*
HAV (1) HepA-Ped 2 Dose	05/02/2006	EAST VALLEY PEDIATRICS	
(2) HepA-Ped 2 Dose	07/21/2008	EASTMONT WELLNESS CENTER	
HPV (1) HPV, NOS	04/04/2013	34580CHILDRENS HOSPITAL OAKLAND PRIMARY CARE	
(2) HPV, NOS	02/20/2014	34580CHILDRENS HOSPITAL OAKLAND PRIMARY CARE	
MENING (1) MCV4, NOS	02/20/2014	34580CHILDRENS HOSPITAL OAKLAND PRIMARY CARE	08/25/2018
MENING B			
ROTAVIRUS			
ZOSTER			

VACCINE *vacuna*	DATE GIVEN *fecha de vacunación*	DOCTOR OFFICE OR CLINIC *médico o oficina*	DATE NEXT DOSE DUE *próxima vacuna*
H1N1			
FLU (1) Flu NOS	12/12/2011	34580CHILDRENS HOSPITAL OAKLAND PRIMARY CARE	
(2) Flu NOS	02/20/2014	34580CHILDRENS HOSPITAL OAKLAND PRIMARY CARE	
OTHER *PCV7	06/23/2003	EAST VALLEY PEDIATRICS	

* Indicates Invalid Dose

DTP = diptheria, tetanus, pertussis (whooping cough) *difteria , tétanos , y tos ferina*
Hib Hib menengitis (Haemophilus Influenza B) *menengitis Hib*
PM 298 (7/98)

MMR = measles, mumps, rubella *paperas sarampión Rubéola*
HEPB = hepatitus B

VZV = varicella (chickenpox) *varicela*
() indicates a dose number in a series

- CALIFORNIA PRE-KINDERGARTEN AND SCHOOL IMMUNIZATION RECORD

CDPH

Pre-kindergarten facility and school staff must record the required vaccine dose information and status of requirements for each pupil. *See reverse side for guidance.*

CAIR PATIENT ID: 269264

PUPIL NAME (LAST, FIRST, MIDDLE)	STATEWIDE STUDENT IDENTIFIER (SSID)	ETHNICITY	RACE
BROOKS, TAZHNAE		☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino	☐ African-American/Black ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other
NAME OF PARENT/GUARDIAN (LAST, FIRST)	BIRTHDATE (MONTH/DAY/YEAR)	SEX	
UNKNOWN, JANEE	08/25/2002	Female	

REQUIRED VACCINE	DATE EACH DOSE WAS GIVEN (MM/DD/YY)					Permanent Medical Exemption	Notes for School Requirements
	1ST	2ND	3RD	4TH	5TH		
IPV / OPV (Polio)	11/18/2002	05/14/2003	06/23/2003 Age : 0 years	07/21/2008		☐	4 doses meet TK/K-12 requirement, as do: 3 doses, if ≥1 dose given at age ≥4 years.
DTaP / DTP — Age 0-6 years **Tdap / Td** — Age 7+ years (Diphtheria, Tetanus, Pertussis)	11/18/2002	05/14/2003	06/23/2003 Age : 0 years	01/27/2004 Age : 1 years	07/21/2008	☐	5 doses meet TK/K-12 requirement, as do: 4 doses, if ≥1 dose given at age ≥4 years; 3 doses, if ≥1 Tdap dose at age ≥7 years; Tdap dose may meet 7th Grade requirement.
MMR (Measles, Mumps, and Rubella)	08/25/2003 Age : > 12 months	07/21/2008				☐	2 doses meet TK/K-12 requirement. Doses must be given at age ≥1 year.
HIB (*Haemophilus influenzae* type b)	11/18/2002	05/14/2003	06/23/2003	01/27/2004		☐	Required for pre-kindergarten only. At least 1 dose must be given at age ≥1 year.
Hep B (Hepatitis B)	09/09/2002	11/18/2002	05/14/2003			☐	3 doses meet TK/K-12 requirement.
VAR / VZV (Varicella or Chickenpox)	08/25/2003	07/21/2008				☐	2 doses meet TK/K-12 requirement.
Tdap — 7th Grade (Tetanus, Diphtheria, Pertussis)	02/20/2014 Age : 11 years					☐	1 dose given at age ≥7 years meets requirement for 7th grade advancement and 7th-12th grade admission.

STATUS OF REQUIREMENTS	Staff Initials *I reviewed pupil's Immunization record*	Has All Required Vaccine Doses	Requires Follow-up: Temporary Medical Exemption	Requires Follow-up: Missing Doses Not Currently Due—Conditional	Requires Follow-up: Missing Doses Are Overdue—Needs Doses Now	Follow-up Date(s) (See conditional admission schedule or exemption end date)	Other *See codes on reverse side*	Date Requirements Met
Pre-Kindergarten (Child care or preschool)		☐	☐	☐	☐		☐ IEP ☐ PBE (pre-2016)	
TK/K-12		☐	☐	☐	☐		☐ IEP ☐ IND ☐ Home ☐ PBE (pre-2016)	
7th Grade (Advancement or admission)		☐	☐	☐	☐		☐ IEP ☐ IND ☐ Home	