HEARING @ 25 dB

DATE: __________ SIGNATURE: ______________________________

Hz	1000	2000	4000	☐ Pass ☐ Fail
R				
L				

VISION

DATE: __________ SIGNATURE: ______________________________

R20/ ________ L20/ ________ Pass ________ Fail ________

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA privacy notice.

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Department of State Health Services
Immunization Unit

Stock No. C-11 Revised 07/2017

School / Child-care Immunization Record

Name: ________________________________ Sex: ☐ M ☐ F

Date of Birth: ________________ Telephone No.: ________________

Street Address: ______________________________________

City, State, Zip Code: ________________________________

School: ____

Parent's Name: _______________________________________

PARENT/PHYSICIAN'S VERIFICATION OF VARICELLA (CHICKENPOX) ILLNESS

This is to verify the person for whom this card was issued had:

☐ Varicella (chickenpox) illness on or about __________ and does not need the vaccine.

______________ ______________________________

Date Parent / Physician's Signature

Name: ______________________________ Date of Birth: ____________

VACCINES	DATE	DATE	DATE	DATE	DATE
Hepatitis B					
DTP/DTaP/DT					
Tdap					
Td					
OPV, IPV					
Hib					
Pneumococcal					
Rotavirus					
HPV					
MMR					
Hepatitis A					
Varicella					
MenACWY					
MenB					
Influenza					
Influenza					
Other					
Other					
Other					

TB Test ___________ Date: ___________ Result: ___________

Date: ___________ Staff Signature: ________________________________

Record hearing and vision on reverse.