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

HEARING @ 25 dB DATE:			SIGNATURE:	
Hz	**1000**	**2000**	**4000**	☐ Pass
R				☐ Fail
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 Department of State Health Services
Immunization Branch

Stock No. C-11
Revised 04/07

School / Daycare Immunization Record

Name: _____ Sex: M F

Date of Birth: _____ Telephone No.: _____

Street Address: _____

City, State, Zip Code: _____

School: _____

Parent's Name: _____

VACCINES	DATE	DATE	DATE	DATE	DATE
Hepatitis B					
DTP					
DTaP					
DT					
Tdap					
Td					
Influenza					
Hib					
OPV, IPV*					*circle one
PCV7					
PPV23					
Rotavirus					
HPV					
MMR				Record hearing and vision on reverse.	
Measles					
Hepatitis A					
Chickenpox					
MCV4					
MPSV4					
TB Test	Date:		Result:		

Date: _____ Staff Signature: _____