DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
IMMUNIZATION REQUIREMENTS

To enroll in DoDEA schools students MUST meet specific immunization requirements. For details: See DoDEA Immunization Requirements, November, 2011. This form is provided to parents to assist with immunization documentation. Medical proof of immunizations must be completed by medical authority and provided to the school officials at the time of initial registration. Medical authorities must sign and stamp their form of choice indicating that immunization records have been reviewed and that the minimum DoDEA requirements are met. At time of registration, copies of prior immunization administration records may be requested to supplement information provided by medical authorities.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. section, 2164 and 20 U.S.C. sections 921-932.
PRINCIPAL PURPOSE: To obtain immunization information needed to enroll students in Department of Defense Education Activity (DoDEA) schools and programs and to promote a safe school environment.
ROUTINES USE(S): DoDEA may release information without prior consent within the DoD when needed to perform an official DoD duty, in accordance with 5 U.S.C. section 552a(b)(1). DoDEA also may release information outside the DoD, in accordance with 5 U.S.C. section 552a(b) (2-12), and the "Blanket Routine Uses," published at http://www.defenselink.mil/privacy/notice/osd. Examples of release may include for valid medical, law enforcement or security purposes, or for use in litigation involving the DoD.
DISCLOSURE: Disclosure to the Agency of the information requested on this form is voluntary; but failure to provide all requested information may result in the delay or denial of student enrollment and services.

Name (*Last, First, Middle Initial*)	**Date of Birth** *(mm/dd/yyyy)*

IMMUNIZATION	**DOSE AND DATE GIVEN**				
	1 (mm/dd/yyyy)	**2** (mm/dd/yyyy)	**3** (mm/dd/yyyy)	**4** (mm/dd/yyyy)	**5** (mm/dd/yyyy)
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis A					
Hepatitis B					
Measles, Mumps, Rubella					
Measles					
Mumps					
Rubella					
Meningococcal					
Polio					
Tetanus, Diphtheria, Pertussis (Tdap)					
Varicella					
Varicella (History of disease.)					
Influenza (Annual)					
PPD	Date Placed:	Date read:	Result: NEG_____mm POS _____mm	MD clearance: YES ☐ NO ☐	BCG

I certify that the minimum immunization requirements have been completed, and or initiated. Immunizations are current until _____

when _____immunization(s) is/are due. **(Date)**

_____
Signature and Stamp of Medical Authority / Date