STATE OF WYOMING-OFFICIAL RECORD OF IMMUNIZATION

Day Care/Pre-School/Head Start/Public and Private Schools K-12

This record is part of the child's or student's permanent record and shall transfer with that record.
Health Department personnel shall have access to this record as deemed necessary.

PART 1 - TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Child/Student_____ DOB_____
Last First MI M/D/YYYY

Parent/Guardian_____ Phone:_____

Address:_____ City_____Zip_____

PART 2 - TO BE COMPLETED BY PHYSICIAN OR HEALTH AUTHORITY

VACCINE	MONTH/DAY/YEAR EACH DOSE WAS GIVEN					
	1	2	3	4	5	6
DTaP, DTP, DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
(Circle Approp.Vac)	DTaP, DTP, DT	DTaP, DTP, DT	DTaP, DTP, DT	DTaP, DTP, DT	DTaP, DTP, DT	DTaP, DTP, DT
Haemophilus (HIB)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
(Circle Approp.Vac)	Pedvax ActHib	Pedvax ActHib	Pedvax ActHib	Pedvax ActHib	Pedvax ActHib	
Hepatitis A	___/___/___	___/___/___				
Hepatitis B	___/___/___	___/___/___	___/___/___	___/___/___		
Hepatitis B (2 Dose)	___/___/___	___/___/___				
Human Papillomavirus (HPV)	___/___/___	___/___/___	___/___/___			
(Circle Approp.Vac)	Gardasil Cervarix	Gardasil Cervarix	Gardasil Cervarix			
Meningococcal	___/___/___	___/___/___				
(Circle Approp.Vac)	MCV4 MPSV	MCV4 MPSV				
MMR	___/___/___	___/___/___	___/___/___			
MMRV	___/___/___	___/___/___				
Pneumococcal	___/___/___	___/___/___	___/___/___	___/___/___		___/___/___
(Circle Approp.Vac)	PCV7 PCV13	PCV7 PCV13	PCV7 PCV13	PCV7 PCV13		PPSV23
Polio	___/___/___	___/___/___	___/___/___	___/___/___		
(Circle Approp.Vac)	IPV OPV	IPV OPV	IPV OPV	IPV OPV		
Rotavirus	___/___/___	___/___/___	___/___/___			
(Circle Approp.Vac)	Rotateq Rotarix	Rotateq Rotarix	Rotateq Rotarix			
Td	___/___/___	___/___/___	___/___/___			
Tdap	___/___/___	___/___/___	___/___/___			
(Circle Approp.Vac)	Boostrix Adacel	Boostrix Adacel	Boostrix Adacel			
Varicella	___/___/___	___/___/___				
If Disease, Date?	___/___/___	___/___/___				
TB Test	___/___/___ (Reactive or Non-reactive)		___/___/___ (Reactive or Non-reactive)		___/___/___ (Reactive or Non-reactive)	

Additional Vaccines (Including Flu)

_____	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
_____	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
_____	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

Signature of Licensed Physician/Designee or Public Health Authority* Date Issued

Street Address Telephone Number

City State Zip Code

*** Health Authority Means any State or Local Health Department Qualified Health Personnel.**

Provided by Wyoming Immunization Section (307) 777-7952 www.immunizewyoming.com

revised by jb, dm and kmc May 2010