

UTAH SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent school record (cumulative folder) as defined in Section 53A-11-304 of the Utah Statutory Code and shall transfer with the student's school record to any new school. The Utah Department of Health and local health departments shall have access to this record. This immunization record may be entered into the Utah Statewide Immunization Information System (USIIS). Licensed early childhood programs in Utah are required to keep this record in each child's file.

Student Information

Student Name _____ Gender ☐ Male ☐ Female Date of Birth _____

Name of Parent/Guardian _____

Vaccine Information

VACCINE	Record the month, day, & year vaccine was given.				
	1 st	2 nd	3 rd	4 th	5 th
DTP, DTaP, DT, Td, Tdap (D-Diphtheria, T-Tetanus, P-Pertussis, aP-acellular Pertussis)					
Tdap (given after 7 years of age)					
Polio (IPV or OPV)					
Haemophilus influenzae type b (Hib)					
Pneumococcal					
Measles, Mumps, and Rubella (MMR) 1 st dose must be received on or after the 1 st birthday					
Hepatitis B (HBV)					
Varicella (Chickenpox)* 1 st dose must be received on or after the 1 st birthday.					
Hepatitis A (HAV) Must be received on or after the 1 st birthday.					
Meningococcal					

SCHOOL AND EARLY CHILDHOOD PROGRAM USE ONLY:

1. ALL REQUIREMENTS MET date: _____

☐ Adequately Immunized

Or Exemption was granted for:

☐ Medical (Expires* on: _____)

☐ Religious

☐ Personal

2. Conditional Admission date: _____

3. Not-in-Compliance date: _____

*If exemption is temporary, student is conditionally admitted; enter date in (2) and leave (1) blank.

Disease Verification:

My child has history of the chickenpox disease, and therefore, does not need the Varicella vaccine.

Signature of Parent/Guardian _____

Age of child at time of disease: _____

* If a student has history of the chickenpox disease, parent must sign to the right.

Utah Department of Health
Division of Disease Control & Prevention
Immunization Program Rev. 12/2014
www.immunize-utah.org
(801)-538-9450

Record Source: ☐ Physician ☐ Registered Nurse ☐ Health Dept. ☐ USIIS

I have reviewed the records available and to the best of my knowledge, this student has received the above immunizations.

Authorized Signature: _____ Date: _____ Title: _____