

# Pro American Educational And Cultural Exchange

WORLD HEADQUARTERS \* 40 WATER STREET, SUITE 700 \* NEW PHILADELPHIA, PENNSYLVANIA \* 17959 \* USA



## Immunization Record (Archivo de Inmunización)

Student (Estudiante) \_\_\_\_\_ Birthdate (fecha de nacimiento) \_\_\_\_\_

Address (dirección) \_\_\_\_\_

City (Ciudad) \_\_\_\_\_ State (Estado) \_\_\_\_\_


Country (país) \_\_\_\_\_ Telephone (telefono) \_\_\_\_\_

**ATTN: DOCTOR:** Pupils enrolled in grades k-12 are required by law to have on file at their school that they have been immunized against DTP (diphtheria, tetanus, & pertussis); poliomyelitis; chickenpox, MMR (measles, mumps, & rubella) and also be tested for Tuberculosis. Failure to do so will result in exclusion from school. If the dates of vaccinations are not current according to the RECOMMENDED IMMUNIZATIONS schedule below, please reimmunize the student at this time.

**Polio must show three dates; Td and MMR must show two dates—initial vaccine & another within the past 10 years. Copies of Spanish documents will not be accepted. If you must update this information again, COMPLETE a new form.**

*Es necesario que todo estudiante de preparatoria presente su historial de vacunas aplicadas durante todas su vida, ya que todas las escuelas verifican cuidadosamente la parte medica. Deberan de tener las inmunizaciones contra DTP (vacuna triple); poliomieltis, varicela, paperas, sarampion y rubeola. Si no cumplen con este requisito no seran aceptados en la escuela. Si al estudiante le falta alguna vacuna, apliquela antes de que salga de su país nativo. Debes tener tres fechas para polio, Td y MMR deben tener dos fechas--vacuna inicial y otro dentro de 10 años. Copias de documentos en español no pueden ser aceptadas Si Ud debe actualizar esta información nuevamente, use un nuevo formulario. Copias de documentos en español no acepta*

### Immunizations Required for School Admittance (Inmunizaciones Requeridas para Admision en la Escuela)

 DIVISION OF COMMUNICABLE DISEASE CONTROL P.O. BOX 90 HARRISBURG, PA 17108		ENTER DATE ONLY IF DISEASE CONTRACTED (Señalar abajo fechas Solo si ha penido la enfermedad escribe fechas: mm/dd/aa	ENTER BELOW THE DATES OF ALL VACCINATIONS IN THE PAST (Señalar abajo fechas de aplicación de las vacunas en años pasados ) escribe fechas: mm/dd/aa	ONLY TODAY'S VACCINATION (Señalar abajo vacunas de hoy) mm/dd/aa																																																																																																																
<b>REQUIRED IMMUNIZATIONS (INMUNIZACIONES REQUERIDAS)</b>		DTP _____ TOPV _____ HEP B _____ Measles _____ Mumps _____ Rubella _____ Chickenpox (varicella) _____ Meningitis _____	<table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>																																																									<table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>																																																								
<b>AGE</b>	<b>VACCINES</b>																																																																																																																			
	DTP Td POLIO MMR Hib Hep B MCV																																																																																																																			
2 months																																																																																																																				
4 months	X	X																																																																																																																		
6 months	X	X																																																																																																																		
15 months	X																																																																																																																			
24 months	X	X	X																																																																																																																	
4 to 6 years				X																																																																																																																
Every 10 years thereafter		X	X	X																																																																																																																
<b>KEY</b> DTP Combined diphtheria, tetanus and acellular pertussis Td Combined tetanus & diphtheria given after six years of age TOPV Polio MMR Combined measles, mumps and rubella Hib Haemophilus Influenzae b Hep Hepatitis B CF Chicken Fox (Varicella) MCV Meningitis (meningococcal conjugate vaccine)																																																																																																																				

Tuberculosis IINE [ ] or PPD [ ] Date \_\_\_\_\_ Pos. [ ] or Neg [ ] TB Vaccine: (opcional) No [ ] Yes [ ] Date \_\_\_\_\_

Chest X-ray: (not necessary if Iine or PPD is negative/ no necesario, si negativo Iine o PPD) ) Date \_\_\_\_\_ Positive [ ] or Negative [ ]

Type Name of Physician: \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Tel: \_\_\_\_\_

We certify that we have reviewed the Health Questionnaire and information supplied by us, and that it is true and complete to the best of our knowledge We authorize any of the doctors, hospitals, or clinics mentioned above to furnish a complete transcript of medical records for the purpose of processing this application

Signature of Student: \_\_\_\_\_ Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_