

# University of Nebraska-Lincoln Children's Center

## Immunization Record

Child's Name \_\_\_\_\_

Male \_\_\_\_ Female \_\_\_\_ Date of Birth \_\_\_\_\_

### DTP/TD (Diphtheria-Tetanus-Pertussis)

### Given By

2 months _____	_____
4 months _____	_____
6 months _____	_____
15-18 months _____	_____
4-6 years _____	_____

### Polio

2 months _____	_____
4 months _____	_____
6-18 months _____	_____
4-6 years _____	_____

### Hib (H. influenza)

2 months _____	_____
4 months _____	_____
6 months _____	_____
12-15 months _____	_____

### MMR (Measles-Mumps-Rubella)

#1 12-15 months _____	_____
#2 4-6 years _____	_____

### Hepatitis B

#1 _____	_____
#2 _____	_____
#3 _____	_____

### Varicella (Chicken Pox)

Date Given \_\_\_\_\_ or \_\_\_\_\_

My child had chicken pox \_\_\_\_\_  
(year)

I certify that the above information is correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date



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