Hawaii National Guard's Youth Challenge Academy

Immunization Record

Name _____
(Last) (First) (Middle Initial)

☐ Female Birthdate ____ /____ / _____
☐ Male

Parent's Name _____ _____
(Mother/Guardian) (Father/Guardian)

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)									
DTaP, DTP, DT, or Td		Pollo (IPV or OPV)		HIB *Haemphilus Influnxae* type B		Hepatitis B	Varicella	MMR	
Type	Date	Type	Date	Type	Date	Date	Date	Date	Check if done
									☐ DTaP
									☐ Polio
									☐ HIB
									☐ HEP
								Measles	☐ MMR
			OTHER						☐ Varic
			Date	Date		Date		Mumps	
								Rubella	

TUBERCOLOSIS EXAMINATION MANTOUX TEST (INTRADERMAL)			
Date Given	Date Read	Results (mm)	Physician, APRN, PA or Clinic

CHEST X-RAY			
Date	Results	Location	Physician, APRN, PA or Clinic

Physician, APRN, PA or Clinic
_____
(Signature or stamp if different from above)

Vision: _____ / _____

Glasses: _____

Comments: