STATE OF WYOMING

OFFICIAL RECORD OF IMMUNIZATION

DAY CARE/PRESCHOOL/HEAD START/PUBLIC AND PRIVATE SCHOOL K-12

Effective June 1, 1999

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

PART I. TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Child/Student _____ DOB _____
Last First MI Month/Day/Year

Parent or Guardian _____ Phone _____

Address _____ City _____ Zip _____

PART II. TO BE COMPLETED BY PHYSICIAN OR HEALTH AUTHORITY

VACCINE	MONTH, DAY, YEAR EACH DOSE WAS GIVEN				
DTAP, DTP, DT (circle one)	1__/__/__	2__/__/__	3__/__/__	4__/__/__	5__/__/__
Td (Adolescent, Adult)	1__/__/__	2__/__/__	3__/__/__	4__/__/__	5__/__/__
POLIO IPV or OPV (circle below date)	1__/__/__ (IPV OPV)	2__/__/__ (IPV OPV)	3__/__/__ (IPV OPV)	4__/__/__ (IPV OPV)	5__/__/__
MMR (Measles, Mumps, Rubella)	1__/__/__	2__/__/__			
SINGLE ANTIGEN (circle as appropriate MEASLES MUMPS RUBELLA	 1__/__/__ 1__/__/__	 2__/__/__ 2__/__/__			
HAEMOPHILUS INFLUENZA (HIB) (Licensed Day Care Only)	1__/__/__	2__/__/__			
HEPATITIS A	1__/__/__	2__/__/__			
HEPATITIS B	1__/__/__	2__/__/__			
HEPATITIS B (2-DOSE) (For Adolescents 11-15 years of age only)	1__/__/__	2__/__/__			
TB test	1__/__/__	2__/__/__			
VARICELLA	1__/__/__	2__/__/__			
PNEUMOCOCCAL OTHER	1__/__/__ 1__/__/__	2__/__/__ 2__/__/__	3__/__/__ 3__/__/__	4__/__/__ 4__/__/__	

_____ _____
Licensed Physician/Public Health Authority Date

_____ _____
Street Address Official Telephone Number

_____ _____ _____
City State Zip Code

*Health Authority means any State or Local Health Department qualified health personnel or school more. Form #1PI-SS-Revised 8/00

Revised 2/1/2006