Comox Valley International Student Program
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IMMUNIZATION HISTORY FOR INTERNATIONAL STUDENTS

(Please print clearly in English)

Child's Full Name _____ Date of Birth *year/month/day* _____

Please indicate the dates child received the following immunizations.

	1st dose Year/month/day	2nd dose Year/month/day (If Applicable)	3rd dose Year/month/day (If Applicable)	4th dose Year/month/day (If Applicable)	5th dose Year/month/day (If Applicable)
TETANUS					
DIPHTHERIA					
PERTUSSIS (Whooping Cough)					
POLIO					
HAEMOPHILUS INFLUENZAE type B					
MEASLES (Rubeola)					
MUMPS					
RUBELLA (German Measles)					
HEPATITIS B					
VARICELLA (Chickenpox)					
MENINGOCOCCAL C					
PNEUMOCOCCAL					
OTHER:					

Physician Name: _____ Physician Signature: _____