



Comox Valley International Student Program

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IMMUNIZATION HISTORY FOR INTERNATIONAL STUDENTS

(Please print clearly in English)

Please indicate the dates when your child received the following immunizations.

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

Parent's Name: _____ Parent's Signature: _____

	1 st dose YYYY/MM/DD	2 nd dose YYYY/MM/DD (If Applicable)	3 rd dose YYYY/MM/DD (If Applicable)	4 th dose YYYY/MM/DD (If Applicable)	5 th dose YYYY/MM/DD (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:					