

North Salem Central School District Immunization Record

Student's Name _____

Date of Birth _____

	Date	Date	Date	Date	Date
Polio (IPV or OPV)					
Diphtheria (DTaP/DTP/DT/TD)					
Tetanus, Diphtheria and Pertussis Booster (Tdap)					
Measles, Mumps and Rubella (MMR)					
Hepatitis B					
HiB					
PCV					
Varicella					
TB Test					
Menactra					

Doctor's Signature _____

Date _____