VACCINE *vacuna*	DATE GIVEN *fecha de vacunación*	DOCTOR OFFICE OR CLINIC *médico o clínica*		NEXT DOSE DUE *próxima vacuna*
INFLUENZA		☐ TIV ☐ LAIV		
		☐ TIV ☐ LAIV		
		☐ TIV ☐ LAIV		
		☐ TIV ☐ LAIV		
		☐ TIV ☐ LAIV		
		☐ TIV ☐ LAIV		
HUMAN PAPILLOMAVIRUS (HPV) 1				
2				
3				
MENINGOCOCCAL (meningitis) 1		☐ MCV ☐ MPV		
		☐ MCV ☐ MPV		

DT/Td = diphtheria, tetanus *[difteria, tétano]*
DTaP/Tdap = diphtheria, tetanus, and pertussis (whooping cough) *[difteria, tétano, y tos ferina]*
HIB = Hib meningitis (*Haemophilus influenzae* type b) *[meningitis Hib]*
HPV = human papillomavirus *[virus del papiloma humano]*
IPV = inactivated polio vaccine *[vacuna antipoliomielítica inactivada]*
LAIV = nasal spray influenza vaccine *[vacuna intranasal viva contra la influenza]*
MCV = meningococcal conjugate vaccine *[vacuna meningocócica conjugada]*
MMR = measles, mumps, rubella *[sarampión, paperas y rubéola (sarampión alemán)]*
MPV = meningococcal polysaccharide vaccine *[vacuna meningocócica polisacárida]*
OPV = oral polio vaccine *[vacuna oral contra la polio]*
PCV = pneumococcal conjugate vaccine *[vacuna neumocócica conjugada]*
PPV = pneumococcal polysaccharide vaccine *[vacuna polisacárida contra el neumococo]*
RV = rotavirus *[rotavirus]*
TIV = flu shot *[vacuna desactivada contra la influenza]*

TB SKIN TESTS* *Pruebas de la Tuberculosis*	Type**	Date given	Given by	Date read	Read by	mm indur	Interpretation
	☐ PPD-Mantoux ☐ Other_____	/ /		/ /			☐ Pos ☐ Neg
	☐ PPD-Mantoux ☐ Other_____	/ /		/ /			☐ Pos ☐ Neg
	☐ PPD-Mantoux ☐ Other_____	/ /		/ /			☐ Pos ☐ Neg

* A chest x-ray may be indicated if skin test is positive.
** If required for school entry, must be Mantoux unless exception granted by local health department.

CHEST X-RAY *[Radiografía]*
(Necessary if skin test positive.)

Film date: ____/____/____ Interpretation: ☐ normal ☐ abnormal
Person is free of communicable tuberculosis: ☐ yes ☐ no
Signature/Agency: _____

Parents: Your child must meet California's immunization requirements to be enrolled in school and child care. Keep this Record as proof of immunization.

Padres: *Su niño debe cumplir con los requisitos de vacunas para asistir a la escuela y a la guardería. Mantenga este Comprobante: lo necesitará.*

IMMUNIZATION RECORD

Comprobante de Inmunización

Name
nombre

Birthdate
fecha de nacimiento

Allergies
alergias

Vaccine Reactions
reacciones a cualquier vacuna

RETAIN THIS DOCUMENT — *CONSERVE ESTE DOCUMENTO*

PROVIDERS: If using combination vaccines, remember to record dose in all appropriate spaces.

Name: Sex: Birthdate:

VACCINE *vacuna*		DATE GIVEN *fecha de vacunación*	DOCTOR OFFICE OR CLINIC *médico o clínica*		NEXT DOSE DUE *próxima vacuna*
HEPATITIS B	1				
	2				
	3				
ROTAVIRUS (RV)	1				
	2				
	3				
DIPHTHERIA TETANUS PERTUSSIS	1		☐ DTaP ☐ Tdap ☐ DT/Td		
	2		☐ DTaP ☐ Tdap ☐ DT/Td		
	3		☐ DTaP ☐ Tdap ☐ DT/Td		
	4		☐ DTaP ☐ Tdap ☐ DT/Td		
	5		☐ DTaP ☐ Tdap ☐ DT/Td		
	6		☐ Tdap ☐ Td		
HAEMOPHILUS INFLUENZAE TYPE B (HIB)	1				
	2				
	3				
	4				
PNEUMOCOCCAL	1		☐ PCV ☐ PPV		
	2		☐ PCV ☐ PPV		
	3		☐ PCV ☐ PPV		
	4		☐ PCV ☐ PPV		
POLIO	1		☐ IPV ☐ OPV		
	2		☐ IPV ☐ OPV		
	3		☐ IPV ☐ OPV		
	4		☐ IPV ☐ OPV		
MEASLES MUMPS RUBELLA (MMR)	1				
	2				
VARICELLA (chickenpox) ☐ Had disease	1				
	2				
HEPATITIS A	1				
	2				