DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (05/2024)

STATE OF WISCONSIN
Wis. Stat. §§ 252.04 and 120.12 (16)

STUDENT IMMUNIZATION RECORD

Instructions to Parent: Complete and return to school within **30 days after admission**. State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission**. The current age/grade specific requirements are available from schools and local health departments. These requirements can only be waived if a properly signed health, religious or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that purpose only. If you have questions regarding immunizations, or how to complete this form, contact your child's school or local health department.

Step 1 **Personal Data** **Please Print**

Student's Name	Birthdate (MM/DD/YYYY)	Gender	School	Grade	School Year

Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, ZIP Code)	Phone Number

Step 2 **Immunization History**

List the **month, day, and year** your child received each of the following immunizations. If you do not have an immunization record for this student, contact your doctor or public health department to obtain it. You may also use the Wisconsin Immunization Registry: https://www.dhfswir.org/PR/clientSearch.do?language=en

Type of Vaccine*	First Dose MM/DD/YYYY	Second Dose MM/DD/YYYY	Third Dose MM/DD/YYYY	Fourth Dose MM/DD/YYYY	Fifth Dose MM/DD/YYYY
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine					
Meningococcal (serogroup ACWY)					

Students with a reliable history of varicella disease are not required to receive the varicella vaccine. Signature from physician, physician assistant, or advanced nurse prescriber required.

☐ I attest that this student has a reliable history of varicella disease,

_____

SIGNATURE – Health Care Provider Date Signed

Has your child had a blood test (titer) that shows immunity (had disease or previous vaccination) to any of the following? Check all that apply.

☐ Varicella ☐ Measles ☐ Mumps ☐ Rubella ☐ Hepatitis B

If **yes**, provide laboratory report(s)

Step 3 **Requirements**

Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

Step 4 **Compliance Data**

Student Meets All Requirements

Sign at Step 5 and return this form to school.

Or

Student Does Not Meet All Requirements

Check the appropriate box below, sign at Step 5, and return this form to school. **Please note that incompletely immunized students may be excluded from school if an outbreak of one of these diseases occurs**.

☐ Although my child has **not** received **all** the required doses of vaccine, the **first dose(s)** has/have been received. I understand that the **second dose(s)** must be received by the 90th school day after admission to school this year, and that the **third dose(s)** and **fourth dose(s)** if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

Note: Failure to stay on schedule may result in exclusion from school, court action and/or forfeiture penalty.

Waivers (List in Step 2 above, the date(s) of any immunizations your child has already received)

☐ **For health reasons** this student should not receive the following immunizations _____

_____ _____

SIGNATURE – Physician Date Signed

☐ **For religious reasons,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap, ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella ☐ MenACWY

☐ **For personal conviction reasons,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella ☐ MenACWY

Step 5 **Signature**

This form is complete and accurate to the best of my knowledge. Check one: (**I do** ☐ **I do not** ☐) give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR.

_____ _____

SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student Date Signed