



# Calvary Early Learning Center Kindergarten Immunization Form

**Due: October 1, 2018**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Address \_\_\_\_\_ Parent or Guardian \_\_\_\_\_  
 Telephone \_\_\_\_\_

Race/Ethnicity  White  Black  Asian or Pacific Islander  American Indian or Alaskan Native  
 Hispanic Origin:  Yes  No

Please Circle Present Grade: K 1 2 3 4 5 6 7 8 9 10 11 12 Sp. Ed.

**PENNSYLVANIA DEPARTMENT OF HEALTH – CERTIFICATE OF IMMUNIZATION**

| VACCINE<br>Circle appropriate item              | Enter Month, Day, And Year Each Immunization Was Given<br>DOSES |       |  |       |       |
|---|---|-------|--|-------|-------|
| Diphtheria and Tetanus<br>(DTaP, DTP, Td or DT) | 1 / /   | 2 / / | 3 / /  | 4 / / | 5 / / |
| Polio (OPV or IPV)                              | 1 / /   | 2 / / | 3 / /  | 4 / / |       |
| Hepatitis B                                     | 1 / /   | 2 / / | 3 / /  |       |       |
| Measles - Mumps - Rubella (MMR)                 | 1 / /   | 2 / / | or Measles Serology: Date Titer              |       |       |
| Varicella (Vaccine or Disease)                  | 1 / /   | 2 / / | Rubella Serology: Date Titer                 |       |       |
| Other   | 1 / /   | 2 / / | Mumps disease diagnosed by a physician: Date |       |       |

Doses required by law for new school enterers (K or 1st Grade) are shaded in green.  
 Age appropriate dose(s) of varicella vaccine or history of disease and 3 doses Hepatitis B vaccine required for entry into 7th grade.

To the best of my knowledge, this child has received the minimum required immunizations. Source  Written  Verbal  Both

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(PHYSICIAN, PUBLIC HEALTH OFFICIAL, SCHOOL NURSE, OR THEIR DESIGNEE)

H502.320 Rev. 2/01

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Address \_\_\_\_\_ Parent or Guardian \_\_\_\_\_  
 Telephone \_\_\_\_\_

Please Circle Present Grade: K 1 2 3 4 5 6 7 8 9 10 11 12 Sp. Ed.

**STATEMENT OF EXEMPTION TO IMMUNIZATION LAW**

**MEDICAL EXEMPTION**

The physical condition of the above name child is such that immunization would endanger life or health.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(PHYSICIAN)

**RELIGIOUS EXEMPTION**

(Includes a strong moral or ethical conviction similar to a religious belief.)

Parent or guardian of the above named child adheres to a religious belief whose teachings are opposed to such immunizations.

State your reason for requesting a religious exemption \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(PARENT OR GUARDIAN)