

MEASLES IMMUNIZATION RECORD

Name: _____
Last First M. I.

IN#: _____ Date of Birth: _____

PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS TO COMPLY WITH THIS POLICY:

VACCINATION RECORD

Date 1st Vaccination: _____ AND Date 2nd Vaccination: _____

Certifying Health Care Provider Name: _____

Address: _____

Health Care Provider Signature: _____

OR

RUBEOLA TITRE (Blood Test)

Date of blood test (antibody Titer) showing immunity: _____

(Please enclose copy of titer results)

Certifying Health Care Provider Name: _____

Address: _____

Health Care Provider Signature: _____

OR

DOCUMENTATION OF NATURAL ILLNESS

Date Natural Illness: _____

Certifying Health Care Provider Name: _____

Address: _____

Health Care Provider Signature: _____

OR

MEDICAL EXEMPTION

Please attach a letter from your physician documenting your need for a medical exemption from this policy.