

The Walworth Barbour American International School in Israel
Certificate of Immunization Form
School Year 2009-2010

TO BE COMPLETED BY A PHYSICIAN, REGISTERED NURSE OR HEALTH DEPARTMENT OFFICIAL

Please attach a copy of your child's official vaccination record

Immunizations marked with an * are required for admission to AIS

Student's Name: _____		Date of Birth: _____				
Immunization	Date Vaccine Given (month, day, year)					
*BCG (Tuberculosis vaccine) or PPD test	1					
*PPD: Date and Results (Tuberculosis screening test)	1	2	3	4	5	
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5	
Diphtheria, Tetanus (DT or Td - given every 10 years)	1	2	3	4	5	
Tdap booster (given after 11 yrs of age)	1					
*Poliomyelitis (OPV, IPV)	1	2	3	4		
*Measles, Mumps, Rubella (MMR)	1	2				
Measles (Rubeola)	1	2				
Mumps	1	2				
Rubella	1	2				
Hepatitis A	1	2				
Hepatitis B	1	2	3			
Varicella (Chicken Pox)	1	2				
Haemophilus Influenzae Type B (Hib Conjugate)	1	2	3	4		
Pneumococcal (PCV conjugate)	1	2	3	4		
Human Papillomavirus Vaccine (HPV Gardasil)	1	2	3			
Other:	1	2	3	4	5	
Serum blood tests to prove serological immunity						

Physician/Nurse signature _____ **Tel. Number** _____

Physician/Nurse Printed Name _____ **Date** _____