MY FRENCH CLASSES IMMUNIZATION FORM

Please note: This immunization form must be completed for each student who attends school outside of Maryland.

STUDENT INFORMATION

Student Full Name:

Date of Birth:

PARENT/ GUARDIAN INFORMATION:

Parent / Guardian Full Name:

Physician Name: Physician Phone:

Name of School and State ____

DPT Date: _______________ Polio Date: _______________ MMR Date: _______________

Is your child exempt from any immunizations on medical or religious grounds? ____ Yes ____ No

Physician Signature **Date**

___________________________________ ______________________