

## PARENT/FAMILY MEMBER IMMUNIZATION CHECKLIST

*For compliance with SB 792 ~ effective September 1, 2016*

*Meets requirements to volunteer/participate in classroom activities*

**\* PLEASE PRINT \***

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

<u>Item to Clear</u>	<u>Date Cleared</u>	<b>Consent to Release</b>
TB – <i>date of clearance:</i> _____ Considered up-to-date if cleared within past 12 months.	____/____/____ <i>Initial</i> _____	<input type="checkbox"/>
Tdap Vaccine – <i>date of administration:</i> _____ Considered up-to-date if received within past 10 years.	____/____/____ <i>Initial</i> _____	<input type="checkbox"/>
Influenza (Flu) Vaccine – <i>date of administration:</i> _____ <input type="checkbox"/> <i>Flu Declination Form (check here) – date of completion:</i> _____	____/____/____ <i>Initial</i> _____	<input type="checkbox"/>
Measles – <i>dates of administration or positive titer:</i> _____ Proof of <u>two</u> vaccines or positive titer required.	____/____/____ <i>Initial</i> _____	<input type="checkbox"/>

~ Medical Office Stamp ~

Signature \_\_\_\_\_ Date \_\_\_\_\_

*With this signature I consent to the release of the medical records indicated above to Riverside Community College District. I certify that my consent for disclosure of this information is entirely voluntary.*

Cleared by: \_\_\_\_\_

Signature: \_\_\_\_\_ MD/FNP/RN/LVN

Date: \_\_\_\_\_