VIIR

STUDENT'S IMMUNIZATION DATA FORM

Name of Facility: _____

Reporting Period: _____

Please **PRINT CLEARLY**, fill out **ALL** of the **REQUIRED DATA** and attach a **COPY** of the student's immunization card. *(If single birth use "1", if multiple birth (twin triplet, etc) use "1" for first born, "2" for second born, etc)*

Birth Status: __ of __

Child's First Name: _____ Middle Init: ____ Child's Last Name: _____

Gender: ( ) Male ( ) Female Home Telephone Number: _____

Date of Birth: _____ Age: _____ Soc. Sec. No.: _____

Physical Address: _____ City: _____ Zip Code: _____

Mailing Address: _____ City: _____ Zip Code: _____

Race: ( ) White ( ) Black ( ) Other (please specify): _____

Ethnicity: ( ) Hispanic ( ) Non-Hispanic

Mother's First Name: _____ Mother's **Maiden** Last Name: _____

Work Telephone Number: _____

Father's First Name: _____ Father's Last Name: _____

Work Telephone Number: _____

I agree and understand that my child's immunization information will be entered in the VIIR and may be shared with schools, daycares, health care providers, and any other health care professionals as necessary to verify immunization status and public health studies.

_____ _____ _____

Parent/Guardian (Please Print) Parent/Guardian Signature Relationship

_____

Date